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# ANNUAL MEETING—MEDICAL AND CHIRURGICAL FACULTY*

## Wednesday Evening, April 29, 1953

## *Osler Hall*

DR. MAURICE C. PINCOFFS: One of the features of this last evening of the meeting, in recent years, and the very pleasant privilege for the President has been to give to the membership and their wives an opportunity to see and hear the President of the Woman's Auxiliary of the Medical and Chirurgical Faculty of the State of Maryland. It is hoped that she will give a brief review of the work of the Woman's Auxiliary. Their work is deeply appreciated by the Faculty. I wish to add my personal compliments for the memorable meeting in the middle of the day.—A very beautiful and pleasant luncheon that gave many of the husbands as well as members of the Auxiliary a chance to hear what I thought was a very remarkable and inspiring speech by the President of the American Medical Association, Dr. Bauer.

You will note on your program that we were to have had the pleasure of having him here at this meeting tonight, but those of you who were at the luncheon know that by this time he is very nearly landing in New Orleans. I turn, therefore, to Mrs. Williams who is this year the very efficient, energetic, and able President of the Woman's Auxiliary of the Medical and Chirurgical Faculty, Mrs. Williams.

### REMARKS OF MRS. CHARLES H. WILLIAMS

MRS. CHARLES H. WILLIAMS: To the Faculty, my sincerest thanks for the lovely flowers that I am wearing this evening.

When my oldest son was just four years old, his Sunday School teacher was very discouraged with his unnecessary activity in her class. One day while she was giving out her Bible leaflets, my son kept jumping up and down yelling for his copy. In desperation she started on a little lecture just for him. She ended this by saying: "John, please, can't you learn to wait? You just must learn patience. Don't you know what patience is?" "Oh yes," my son explained very quickly, "sick people." I hope you will have a little patience with me, tonight, because I simply must review some of the highlights of your Auxiliary year.

Our Auxiliary, in an effort to get out the votes, joined the Ballot Battalion, a non-partisan group. We organized baby-sitting centers in doctors' offices and churches all over the city. One of our counties took care of telephone calls

* Transactions of 1953 of Medical and Chirurgical Faculty are completed with this issue except for the Presidential Address of Dr. Maurice C. Pincoffs.

for their entire area for all information and service during the election day. Recently we were notified that our work helped the battalion win a major award in a contest sponsored by the American Heritage Foundation.

The booklet "Winning Ways With Patients" was placed in many business offices and high schools for training secretaries and receptionists. Four of our counties sponsored Health Exhibits at Fairs. Medical literature was given out to thousands. We have worked on Civil Defense, Cancer and Medical research programs.

A resolution to honor the physician successfully passed our legislature and most county physicians were honored in some way.

Future nurses clubs were organized in many schools. We helped various other groups obtain medical films for their programs. All of our organized counties now have nursing scholarships, and one county had to cut theirs in half because the award was won by twin sisters. High schools were visited and hospital tours conducted. A nurse recruitment film is being made of our nursing schools at a cost of Twenty-Five Hundred Dollars. The fund for this was made up from contributions. A reception was held to honor the nurses in practice. Various things were done for nurses' homes, such as the purchase of television sets. One county now gives an award to the nurse graduating with distinguished all-around efficiency.

On May 12th, this year, the first future Nurses Convention in the United States will be held here in this hall. This is a scientific session modeled after the doctors convention, with films and outstanding speakers. Already we have almost four hundred written reservations for girls who are interested in nursing to attend this affair.

Last but not least we supported both of our Medical Schools by contributing to the American Medical Education Fund, and, of course, you all enjoyed the wonderful Ball on Monday evening.

To our new President, Mrs. John G. Ball, I would like to leave a story that my father repeated often to me when I was a youngster, of the two frogs that fell in a cream pitcher. One kicked a little bit and then sank to the bottom, while the other kept kicking and the first thing it knew it was floating around on top, on a ball of butter. Thank you.

DR. PINCOFFS: I have another pleasant duty, Mrs. Williams, and that is to present to you these flowers and to read this letter which I should also like to read to the audience. It comes from and it is signed by the President of the Baltimore County Medical Association and is addressed to Mrs. Williams:

"We in Baltimore County are proud to have had you as the President of the Ladies Auxiliary of the Baltimore County Medical Association. We are further complimented that you were selected to fill the Presidency of the Ladies Auxiliary of the Medical and Chirurgical Faculty of Maryland. It is therefore a very genuine 'well done' you have earned, and now we wish to express to you our appreciation and best wishes."
(APPLAUSE)

## TESTIMONIAL TO DR. HARVEY B. STONE—PRESENTATION

DR. PINCOFFS: I shall now call on Dr. Chatard, who has a function to perform.

DR. J. ALBERT CHATARD: I am in a quandary. There is no definite indication in the program just why I am here. I am sure you are all wondering. Although I'm Treasurer of the Faculty, this is not a plea for funds or anything like that. However, as Curator I have a very wonderful duty to perform tonight.

"*The good man does, is oft interred with his bones.*" How much more pleasant it is to say nice, well meant things about one who is present; still with us; active; and much alive to all the problems of modern life! Many, many times, por-

traits, books and other valuable mementoes are presented to your Faculty; a long or a short while after the one so honored, has departed.

Tonight this is reversed and the one to be honored is closely with us, Dr. Harvey B. Stone. Words of praise are embarrassing to many people, but are pleasing to all of us when so clearly deserved as on this occasion; now just a few words that come from my heart, Harvey!

We have been together for many years, on many committees during our work at the Faculty. I know only too well how many times I have watched you in the Council and other meetings holding the lid down with patience, forebearance and quietly aiding the discussion to drift to its proper solution under your guidance. No one could have done a better job and all our members are deeply indebted to you for your work. My few feeble words cannot adequately express my feelings.

As Curator of our Faculty (a position very recently acquired by me) it would be amiss, if on this occasion, I did not extend to all our past and present friends and associates, thanks for the wonderful things we have inherited and must preserve for future generations. I don't think our membership fully appreciates all that is housed in these hallowed walls; so much we have and I hope much more will come in the future.

Now, it is my most pleasant duty to present to the members of the Faculty, this most beautiful silver service as a gift from Mr. and Mrs. Brinton H. Stone, Dr. and Mrs. Douglas H. Stone and Dr. and Mrs. George H. Yeager in honor of their father, Dr. Harvey B. Stone. On the oval tray is engraved, the seal of the Faculty with the notation that Dr. Stone was President, 1941, member of the Council 25 years, and Chairman of the Council 5 years.

To you now, Dr. Pincoffs, as President of the Faculty I wish to present this silver service in the name of the Stone family.

Dr. Pincoffs: I am very glad to be in the President's position to accept this very fine gift in the name of the Faculty honoring one whom I have known closely for thirty years and have been privileged to sit with in the Council of this Faculty for a long time. I shall not attempt to narrate all the history of Dr. Stone's medical life and the honors he has won. Many of us here have known him only as a modest man whom we all have trusted as to his fairness, his judgment, and his wisdom. We have looked to him for help in all the affairs of medicine in the State. Perhaps a number of you don't realize the national position he has held; how, after his service in World War I, he kept in relation to the military affairs in Washington, and throughout the entire interval between the wars; and during the last war he was called on for advice in an administrative way to the military service. Nor may you realize what an important part he has played in the National affairs of medicine, first as our delegate and later on the A.M.A. Council on Medical Education and Hospitals. We do know, I am sure, and appreciate the position he has won in his field in surgery, as a teacher and investigator and as a most able surgeon.

I am glad to say that modest as he may be and although retiring to a position way back in the hall, I am in a position to ask him to come forward now. (APPLAUSE) It is not the purpose to suddenly thrust on him a task of saying much; it is because there is another small ceremony to perform this evening in connection with Dr. Harvey Stone.

As President of the Faculty, Harvey, I have been asked by the American Medical Educational Foundation to present to you a National Award of Merit which reads:

> "To Harvey B. Stone for your outstanding contribution for the preservation and continuance of the high standards of Medical Education in the United States of America."

This Foundation is deeply indebted to Dr. Stone for his services as Vice-President of the organization and his loyal, generous and untiring

support since the inception of the program to keep our medical schools free and independent institutions with continued high standards.

(PRESENTATION)

DR. HARVEY B. STONE: I am deeply touched and deeply embarrassed. You know, DR. CHATARD has quoted from William Shakespeare, I believe, and I think a part of that same speech could be modified for this occasion to read:

"I have come to praise Caesar, not to bury him."

And I think perhaps it was easier on Caesar in the first version.

I am tremendously affected by the fact that my children who know my weaknesses and shortcomings still thought enough of me to do this. Thank you.

(OVATION)

# THE CHANGING NATURE OF MEDICINE*

J. S. L. BROWNE, M.D.C.M., PH.D., F.R.S.C., F.R.C.P. (C)., F.A.C.P.†

*Dr. Pincoffs:* The Ridgeway Trimble Fund Lectureship has always been a feature of the annual meeting. It is usually on the last night and it is attended by a more varied and in many ways a more charming audience than the purely technical meetings. When we invited our speaker of tonight to come here, we told him that if he chose a subject more broad in nature than any single contribution, it would fit the occasion very well. I know that you will be stimulated because Dr. Browne, Professor of Medicine at McGill University, and Director of the Department of Medicine in the Victoria General Hospital in Montreal, has in addition to his many contributions in the more technical side of medical research, always been interested in the philosophical side of medicine and has a gift of presentation that I am sure is going to be a great delight to us all. I take pleasure in introducing Dr. J. S. L. Browne.

*Dr. J. S. L. Browne:* When the letter from Dr. Compton came, I wanted to know whether I was to be scientific, humorous or philosophical. I did not ask to be philosophical, I was told I had to be philosophical. I've forgotten who it was who said that he tried to be a philosopher but cheerfulness would keep breaking through. I trust that cheerfulness will occasionally break through this discussion. If it doesn't you can all leave from time to time, as the musicians do in Haydn's "Farewell Symphony," if you remember.

My title is "The Changing Nature of Medicine." In French there is a phrase, "Plus ça change, plus ç'est la même chose," which means, the more it changes, the more it remains the same thing. As that is true I am not quite sure what it is I am going to talk about, regarding the changing nature of medicine.

However, a little while ago we had at the Sigma Chapter at McGill, a symposium on the "Criteria of Proof in Various Sciences." There were a physicist, a biologist who is an entomologist, a cellulose chemist, and myself. We had to have five luncheon meetings in order that we could begin to discuss with each other at all because, of course, each didn't understand a word the other said to begin with, and after about five luncheon meetings (and they were by far the most interesting part of the whole affair) the physicist suddenly said: "Hmm—yes, we used to say that light was either corpuscular or wavelength, and now we say light is light and it behaves this way; we have the operational point of view." "Why yes," said the entomologist, "We used to stick pins in bugs and say 'this is this species, this is this species, this is this species,

* I. Ridgeway Trimble Lectureship presented at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, on Wednesday evening, April 29, 1953, in Osler Hall, 1211 Cathedral Street, Baltimore, Maryland. (Transactions, 1953.)

† Professor of Medicine, McGill University, and Director, McGill University Clinic, Royal Victoria Hospital, Montreal, Canada.

and now we seem to find that the species tend to merge into each other and this is very awkward.' " "Why, yes," said the psychologist, "we used to characterize definite characteristics and label them and put them down and now, all sorts of difficulties have come up and we are not quite sure where we stand." At the symposium itself, Dr. David Thomson, who is Professor of Biochemistry, summed up, by saying that we used to think we could attain definite truth, and now we think that truth is a black speck in the middle of a cloud and we're not quite sure there's a speck there.

It seemed to be rather an odd sort of affair to get approximate agreement between scientists of quite different disciplines as to some sort of vague thought like that, and it reminded me of what could be called the concept of "mental climate," which was used by Whitehead to indicate the ambience in which the science, the art, the politics of an era grow and develop. It seems to me in looking over a very short period of time, that certain events in medicine recently have perhaps brought forward a little bit more the kind of rather vague point of view, which was taken at that symposium.

It is a very irritating point of view, most people don't like it. I didn't like it myself very much, but I think it has perhaps been useful in at least allowing us to reconsider certain of our attitudes in medicine, and to have become perhaps not necessarily from the practical but from the theoretical point of view a little less definite than we used to be, that we knew definitely much of what there was to know.

In the following you will see I am taking part in the same way as all medical people take part in the growth of medicine. One may liken this growth to a tree which grows from a seed, branches, then flowers, goes to seed and then another tree grows and thus is continuous. Each person in the course of his development in medicine, grows along with the subject, then he flowers, then he may go to seed and then another generation comes along and as this process goes on there is a good deal of personal difficulty which goes along with the process of which I shall speak a little later.

First of all, with regard to Medicine, I think one can divide it properly into three parts: its science, its art and its spirit. Its science is what I propose to talk about first, and it has seemed to me from the educational point of view, that eighteenth century materialism become differentiated through strict nineteenth century morphological pathology into medicine. So that since man is ever desirous of certainty, and since I am now speaking of the science of medicine and not its art or its spirit, there came about a view at the beginning of this century and it still persists, that the interest in the patient was as the inverse square of his distance from the autopsy table. That, of course, was because at the autopsy table people thought they could be certain this is the way students should be taught, and the interest lay very largely along those lines. This point of view hasn't really altered; it is only altered in the way in which further facts to obtain certainty are obtained as I shall point out.

The spirit of medicine is quite a different thing. It has been present ever since one man said, "I'm not well, will you help me?" That has been from the time of primitive man until now and it hasn't altered at all, and it seems to me that the art of medicine is the application of the science of the day in the light of the spirit. The art of medicine then will also be a continuous changing thing; it will not always be the same. It is this continuous growth and changing which leads, as we shall see to misunderstanding and difficulty, and to resentment of the attitudes of different ages and of different generations. Actually the spirit changes very little; the science changes and so does the art.

From the scientific point of view we feel that in the last twenty or thirty years, our capacity to learn scientific facts about the patient before his death has been increased. Our senses have been extended in many ways, and physiology, biochemistry, biophysics, etc., have come to be

applied to medicine for the obtaining of additional facts.

However, I would point out to you that since we are conditioned by our medical childhood just as surely as we are conditioned by our actual childhood, and since in most people's medical childhood and in the generation before that, the autopsy table was the sanctum of truth, one needs twenty tests to equal one autopsy table for certainty and consequently a great many tests are done and patients become scattered all over the lot of specialism and of determinism. This process has been going on for a long time. It isn't in any way new. I would point out that it is not the extension of our senses by apparatus and chemical and physical determinations which make us forget the art and the spirit of medicine; it is using them as an excuse for not thinking or feeling.

Of course, this is all very unsatisfactory, so again, people have felt that Humpty Dumpty should be put together again and what follows is in no way disparaging to the efforts of people to put him together again. It is highly desirable, but in the course of being put together again a large number of the pieces were put together but there was rather a large crack around the two parts of the egg, and if I may, I prefer to transfer the metaphor rapidly to call the crack a fence: the psychosomatic fence.

The psychosomatic fence is a bright, white-painted picket fence on a green lawn which has no fence on it, and the medical people constantly fall over the fence on one side, and the psychiatrists fall off it on the other and there isn't any fence there.

A new term has come in recently which is called comprehensive medicine, and the intention is to seal the crack up and to perceive the green lawn though whether the last will be accomplished I am not as yet sure.

In medicine, it seems to me that our tendency to have very definite views about diseases, to give them definite names and to believe that they are true entities, all of them independent of each other, has altered somewhat recently. The above is an exaggerated statement, of course, of what went on before because, the concept of the host response has certainly been considered for many years. That concept has received a considerable degree of redirection of attention to it by the concept of the adaptation syndrome put forward by Dr. Hans Selye.

Now, in essence, the concept of the adaptation syndrome states firstly, that the organism reacts in the same way to a variety of different damaging agents, for example, to cold, to morphine, to adrenalin, to fright, etc.; secondly that as you go on damaging an organism, it changes its reaction in time; and thirdly, that it matters whether the organism has been damaged before as to how it reacts to a second damage. I have no intention of going into the analysis of the scientific details of this, but those are the main principles.

The substances ACTH and Cortisone have come along with the discovery by Hench and Kendall, and they have been found to affect a very large number of apparently quite different and certainly differently named diseases. I freely confess that I, myself, and I think quite a large number of people felt that this was a very great advance, perhaps a panacea. I can remember, to misquote Shakespeare at the first ACTH conference that this came to me after the meeting:

> "To be or not to be? that is the question.
> Whether 'tis nobler in the mind to suffer
> The slings and arrows of outrageous stresses
> Or by a stroke to end them all; to A, to C,
> To T, to H, that is the question?"

Now that, of course, is the feeling which commonly happens with many new things and remedies. It does, however, remain that ACTH and Cortisone do affect symptoms and processes in the body in a vast number of apparently different diseases.

On a vacation in Gaspe in 1950, when I was trying to get away from ACTH and Cortisone, I invented an "iceberg" of disease.

As you know, an iceberg floats with about seven-eighths of its bulk below the surface. The

whole of the iceberg represents the signs and symptoms of diseases as we know them. We know how diseases were named: somebody observed that somebody was sick, had certain symptoms and then listened or looked or heard or felt certain things; when the patient came to autopsy certain findings were made and after several patients had been found to have the same signs and symptoms and the same findings at autopsy, these were related, and then a name was given and this then became a disease entity.

The parts of the iceberg may be regarded as representing different diseases. Let us call one part tuberculosis, one, lobar pneumonia, one, asthma, one rheumatic fever and one, rheumatoid arthritis. The projections of the iceberg above the surface, the peaks in other words, may be regarded in two ways: first, as the overt or apparent aspects of the disease. Each individual peak may represent the special reactions of the body to the particular environmental influence—for example—all those things the body does about the tubercle bacillus and not about anything else, about the pneumococcus, about the allergen. Underneath the surface, the mass of the iceberg represents the general reactions of the body, those things described in the adaptation syndrome and I am sure a large number of others not so described. These reactions have been called non-specific but that isn't quite true; unless both the special *and* the general reactions are present, the disease is not.

If we apply Cortisone or ACTH we melt the iceberg (alter the general reactions) and that part with its peak sinks below the surface and the overt disease disappears. It is still there but it isn't apparent; when one stops treatment, the iceberg reforms and the disease appears again as for example, in the case of rheumatoid arthritis. It is also true, for example, that some of the peaks (or special reactions) can be present below the surface for years. For example, the special reactions of tuberculosis can be present in the body for many years before the overt disease appears; due perhaps to an alteration in the general reactions of the body occasioned by starvation, another acute disease or an emotional upset, can lead to the disease becoming active and apparent (to the peak appearing above the surface). We know that ACTH and Cortisone can affect the general reactions of the body and I submit that the pituitary and the adrenal have been present in the body many years before anybody discovered ACTH or Cortisone and have been reacting to stresses and that these reactions may influence the appearance, disappearance and severity of disease depending upon the special reactions present in the body at the time.

We know that psychological influences affect the output of the adrenal cortex and therefore this is one connection between emotion and the underlying broad common area of the iceberg which takes part in many diseases but which is not itself the disease. In other words it is necessary to have both the special and the general reactions for the disease to be characterized as the disease as we know it, and if you were to interfere with either the special reactions or with the general reactions, then the disease ceases to be the disease as we know it. You are well aware of the fact that if you give ACTH and Cortisone, you may so distort the disease processes that it is very difficult for our clinical judgment to recognize, or to realize its severity.

This is all of course partly speculative. It is, however, I think, the case that we can no longer say this is this disease, this is that disease, and they are all separate (as the entomologist's species). However there is an inter-relation between them though naturally the relative importance of the special or the general reactions in the disease varies under different circumstances.

There is at the moment a reaction against this concept as always happens and it has been pointed out quite clearly that the concept that the body reacts in the same manner isn't strictly true. However, the concept still has value in the sense that it does point out that in many diseases the host response is similar or the same and that

by modifying that response, you can markedly alter the overt manifestations of the disease.

I might just mention the phrase I put in the abstract and that is what I described as the "net" versus the "chain" concept of causality. We have the strands of a net and let us say we have an indicator. If one of these strands breaks, the whole net is going to rearrange itself. The indicator will move, and it may move in the same direction whether it is this or that strand which breaks. So for example, if we are to conceive of edema as being the indicator influenced by so much deficiency of protein; so much retention of salt, so much anti-diuretic effect and so much something else, the relative importance of these strands of the net will vary. If we fix our attention on one strand and find low blood protein and say—ah, that is the cause of the edema—and so we hang our hat and fix our therapeutic attention on that strand perhaps to the neglect of the other strands which may sometimes be quantitatively more important.

To turn to a more general concept, I want to read a short paragraph out of the book called "Science, Sense and Nonsense" by Synge, who is Professor of Theoretical Physics at Trinity College Publinii. Though it is difficult and painful, the difficulties and pain are due to confusion. From time to time with enormous intellectual effort, someone creates a little order, a small spot of light in the dark sea of confusion. At first we are all dazzled by the light because we are used to living in the darkness, but when we regain our senses and examine the light, we find that it comes from a farthing candle, the candle of common sense.

"The sages chase their own tails throughout the ages. A little child says: "Gentlemen, you are chasing your own tails." The sages gradually lose their angular momentum and glancing over their shoulders see what they are pursuing, but most of them cannot believe what they see and the tail-chasing does not die out until a generation is passed."

I have indicated some of the difficulties and alterations which have occurred in medicine and which are constantly occurring both in medicine and in medical people. There is no way of halting this. It can't be halted and ought not to be halted. But how can people understand each other a little better? Well, I can tell you exactly how it can be done: what it needs is a sympathetic understanding, and absence of the interdisciplinary jealousies and of personal insecurity and a study of semantics! Of course, as you see, this is either an ideal or a pious hope because the attainment of all these is next to impossible even though we attempt it.

With regard to a generation of medical men and their conditioning by their medical childhood as each generation comes along, I might quote to you the example of the word "functional." When I was a medical student "functional" meant, not morphologically apparent; that is due to some physiological or biochemical disturbance. It now means "psychogenic" or caused by mental disturbance. It has retained its philosophical point of view because it means incomprehensible in either case, depending upon the time at which it was said.

Another example of the point of view of medical men of different ages, is the story of Dr. Holmes and the poem he composed when the stethoscope was first brought back from France by younger American medical men. The poem describes this instrument, a short wooden instrument, and that the young doctor used this new kind of device a great deal too much, and, two flies got inside the tube of the stethoscope and they made a buzzing noise, and the diagnoses that he made using this new fangled device were of course very, very erroneous indeed. We now accept the stethoscope as a normal "article of diet," if I might put it that way, but you will see that the point of view changes with the medical generations.

And now, to illustrate this further I'd like to quote an anonymous poem (with apologies to Gilbert and Sullivan). This is called "The Scien-

tific Medical." It is a parody on the "modern major general" song.

I'm the very model of a scientific medical
I know each nerve and artery, each ligament and pedicle.
My knowledge has been built by evolutionary processes,
From Galen and Hippocrates to present day Collossuses.
I've studied all the endocrines and know the various offices,
Of pancreas and thyroid or of thymus and hypophysis.
I know the suprarenals, too, and all that they're related to,—Related to,—related to,—
How benighted were the medicoes who lived in 1882.

I know the pH value of ionical acidity,
I calculate percentages with wonderful rapidity,
And when it comes to artery or ligament or pedicle,
You'll find I'm just the model of a scientific medical.

I'm particularly expert at a Wassermann analysis,
I hunt for protozoa in a patient with paralysis.
The chemistry of insulin's a subject that I revel in,
And antitoxin therapy I'm just the very devil in.
I know the role of calcium in various forms of tetany,
I understand trypanosomes although I've never met any.
And I've the latest news on perineural—sympathectomy —ectomy—ectomy.—
My knowledge often bringing in a good substantial cheque to me.

I'm very good at vitamins and matters dietetical.
I know the graphic formulae of remedies synthetical,
And when it comes to artery or ligament or pedicle
You'll find I'm just the model of a scientific medical.

When I've acquired some knowledge about matters pharmaceutical,
When I can diagnose a little deeper than the cuticle,
When simple indigestion has become a trifle clear to me,
When babies with the colic are no more a source of fear to me;
When I can write a recipe with ordinary galenicals;
And when I know the doses of the various arsenicals;
When highbrow scientific lore no longer needs a missioner,
You'll then consult me safely as a general practitioner.

For my scientific knowledge though I'm always up-to-date with it,
Has kept me back with practice and I'm just a little late with it
But when it comes to artery or ligament or pedicle,
You'll find I am the model of the scientific medical.

The above appeared anonymously in the Journal of Chemistry and Industry, in 1929. Nobody knows who wrote it.

It illustrates definitely what I have just pointed out. People do think other people do not have the art of medicine or the spirit of medicine, etc., and it is a continuous process. There is, then, the necessity for the desire to communicate and then the great semantic difficulties of finding the words with which to do so. Examples of difficulties of communication follow. With regard to this, John Buchan who was Lord Tweedsmuir, when Governor General of Canada, gave a speech on the use of English, and he said quite truly that our scientific specialism has now gone so far with regard to jargonization; that each group can only communicate with those immured in the same mausoleum. In the use of words, one group of people will use one word to mean one thing, another group will use it quite differently. "Stress," for example, is a dreadful word. It has been used for all sorts of things. So is "shock," and if you talk about "shock," for example to different people, you will find yourself in the same position as I am when I go to Boston. Somebody says the MGH, and I instinctively think of the Montreal General Hospital while of course it is the Massachusetts General Hospital.

It may apply to a medical student taking a case history at the bedside.

"One day while passing through the men's ward, the author observed an intensely occupied student seated beside a bed, his head bent over a pad on which he was writing vigorously. Next to his notebook lay the "Outlines of medical history." During a period of fully ten minutes, the student never raised his head to look at the patient whose story he was recording. As rapidly as possible, categorical questions ascended from his downward pointing lips, and he as rapidly wrote down the equally categorical, and often monosyllabic answers. From time to time one could see above his bent head that the patient had his tongue in his cheek and winked knowingly across the ward at some understanding crony. The deductions from this situation are obvious. The historian and his patient met as strangers and remained strangers to the end of the interview. The young doctor completely oblivious of the

man in the bed, sought only to fill out a required blank which—indeed—remained a blank. The patient, equally disinterested, was annoyed and bored by the detached questioning. He, like all patients, was hoping for a physician with special understanding, not of forms and of medicine but of himself. Here, again, we see the challenge of wisdom to science."

That is a description of a student. In Montreal, we have a number of people who speak French as their mother tongue. Though this is not the place to discuss it, I feel very strongly that no one can practice medicine in the Province of Quebec unless he can understand French really well, because it is unfair to ask anyone to express themselves when they are ill, except in their mother tongue. Furthermore they cannot do it and a truly good medical history cannot be obtained.

I was going down the ward once, and there was a French Canadian man who had had a coronary thrombosis. The scientific aspects of the diagnosis were well established, but the students would not believe he had had a coronary thrombosis because he had had no pain, and so I said to him: "Qu'est-ce que c'est que vous-avez senté?" "What did you feel?" And he said: "C'etait comme si on avait une grande joie ou une grande tristesse." "It was as if one had had a great joy or a great sorrow." Now if you will remember, that angina, anguish, anger, anxiety, angst, angor, anxieté are all basic words. They come from the Aryan root word *ang* which means a strangling pain. We speak of angina, and here, then is a sound which has been used by humanity in many languages for a long period of time to express what in part this patient expressed. Here we see a reflection of an emotional situation from an organic lesion, and yet that word has been used as I say, in many languages. I think it profoundly illustrates the fact the words we use in medicine are often based more deeply than we realize.

We say "crushing" or "anguish"—we are using words which have been used for many centuries by man, to express certain rather deep feelings and sensations. We also medically—speak of angina as a sore throat. Well, the other day Dr. G. R. Brow called me in and said: Look at this electrocardiogram. Do you know this man has been to three of our Nose and Throat Specialists because he had a sore throat. He only had a sore throat when he exercised. He had *angina pectoris*. So there you have the same word again, and in that instance it is mixed up practically and scientifically, but it is related to that sensation which has been expressed in many other common non medical words.

Another great difficulty in understanding is illustrated by the story that Oliver Wendell Holmes tells in the Autocrat At The Breakfast Table of six people in a conversation. John and Tom were conversing. Now the six people were: The real John—(whatever that may be)—John's John and Tom's John and so for Tom. Now let us suppose that John is really a stupid person, thinks himself extremely brilliant, and Tom considers him an artful rogue. It's a wonder says Holmes that they understand each other at all. And that is a continuing condition and it is extremely difficult to get over and that is as true of patients as it is of one's friends, as it is of one's enemies. Still, it seems to me that this is part of the difficulty of medicine; it is part of the difficulty of communication which we have in some way to get over.

Now, another thing which makes communication difficult at scientific meetings is the insecurity of the doctor, and he is more insecure when he is in his own local place than he is when he is at a meeting outside. You know the definition of a visiting fireman is an ordinary guy far from home. Well, that is true. I must say I'm afraid it is true of local meetings in a hospital, that the fear of what Dr. Dash would say usually prevents people from talking at all, for fear of their practice being affected. To illustrate I want to read (slightly paraphrased) to you from a small book published in 1913 called "Microcosmographia Academica" by F. M. Cornford, who used

to be Professor of Greek, in Cambridge, England. It is called a guide to the young academic politician, and it is applicable far outside the walls of the university or hospital:

> Let us first consider the political motive.
> (This is addressed to the young academic politician between the ages of 25 and 35.) You will begin, I suppose, by thinking that those people who disagree with you and oppress you, must necessarily be dishonest. Cynicism is the besetting and venal fault of declining youth and disillusionment its last illusion. It is quite a mistake to suppose real dishonesty is at all common. The number of rogues is about equal to the number of men who act honestly, and it is very small. The great majority would rather behave honestly than not. The reason why they do not give way to this natural preference of humanity is that they are afraid that others will not, and the others do not because they are afraid they will not. Thus it comes about that, while behavior which looks dishonest is fairly common, sincere dishonesty is about as rare as the courage to evoke good faith in your neighbors by showing that you trust them. No, the political motive in the academic breast is honest enough, it is fear, genuine, perpetual, heartfelt timorousness, and we shall see presently that all the political arguments are addresses to this passion. Have you ever noticed how many people say "I'm afraid I don't" when they mean "I think I don't." The proper objects of fear, hereafter to be called "bugbears," are in order of importance: "Giving yourself away, females, what Dr. Dash will say, the public washing of linen, the great world outside."

Pornforo's Political Parties I think are interesting. You remember this was written in 1913. He writes: "But first I'd better describe the parties, in academic politics and it is not easy to distinguish them precisely. There are five and they are called Conservative Liberals, Liberal Conservatives, Nonplacets, Adulamites, and Young Men in a Hurry. A Conservative-Liberal is a broadminded man who thinks that something ought to be done, only not anything that anyone now desires but something which was not done in 1881. A Liberal-Conservative is a broadminded man who thinks that something ought to be done, only not anything that anyone now desires and that most things which were done in 1881 ought to be undone. The men of both these parties are alike in being open to conviction, but so many convictions have already got inside that it is very difficult to find the openings; they dwell in the valley of indecision.

The Nonplacet differs from these in not being open to conviction; he is a man of principle. A principle is a rule of an action which states a valid general reason for not doing in any particular case what to unprincipled instinct would appear to be right. (The Nonplacets believe that it is always well to be on the safe side which can easily be located on the "no side" of any question.)

The Adulamites are dangerous because they know what they want, e.g. all the money there is going. They inhabit a series of caves near Downing Street. They say to one another: "If you'll scratch my back, I'll scratch yours. If you won't, I'll scratch your face."

The Young-Man-In-A-Hurry is a narrow-minded and ridiculously youthful prig who is inexperienced enough to imagine that something might be done before very long and even to suggest very definite things. His most dangerous effect being want of experience; everything should be done to prevent him from taking part in affairs. He may be known by his propensity to organize societies for the purpose of making silk purses out of sow's ears. This tendency is not so dangerous as it might seem, for it may be observed that the sows, after taking their washing with a grunt or two can go back unharmed to the wallow and the purse market is reported as firm.

So that illustrates some of the difficulties of understanding communication and organization in medicine. Actually this all sounds so difficult one would think nothing can be done about it. I still think that a great deal can be done about it by sympathetic understanding and by some form of modification of the ideal which I enunciated. I would like for your comfort to end by quoting a poem which, I believe, was composed by Alec Templeton, and is entitled, "Friendship":

> Oh the comfort
> The inexpressible comfort of feeling safe with a person
> Having neither to weigh thoughts nor measure words,
> But, putting them all out just as they are
> Chaff and grain together

Certain that a faithful hand
Will take them and sift them
Keep what is worth keeping, and with a breath of kindness
Blow the rest away.

And that, ladies and gentlemen, is the spirit of Medicine.

*Dr. Pincoffs:* Dr. Browne, I think the audience has shown its immediate appreciation of what you have said. I have the pleasure of presenting to you the Ridgeway Trimble Medal as a memento of this occasion.

And this, Ladies and Gentlemen, brings us to the end of this session of the Medical and Chirurgical Faculty.

* * * * *

## *GAMMA GLOBULIN FOR MEASLES AND HEPATITIS*

Source From National Foundation for Infantile Paralysis

Recently, the National Foundation for Infantile Paralysis completed negotiations for the purchase of the present inventory of certain processors of commercial gamma globulin as well as the future production by these same producers. In agreement with the American National Red Cross all gamma globulin processed from Red Cross donated blood, as well as the commercially produced gamma globulin purchased by the National Foundation, has been placed under control of the Office of Defense Mobilization. The National Foundation does not have in its possession or control any supply of the blood fraction.

It has been agreed by all parties concerned that gamma globulin will be available for measles prophylaxis and for use by physicians in the treatment of infectious hepatitis, irrespective of the resulting limitation of gamma globulin available for use in poliomyelitis epidemics.

The Office of Defense Mobilization will allocate the available gamma globulin through State and Territorial Health Officers for use in measles and infectious hepatitis, and will make additional distribution for the purpose of controlling poliomyelitis.

Physicians who are unable to purchase gamma globulin through their regular drug supply channels are advised to request supplies from their local or state health departments. There will be no charge for this gamma globulin, since the Red Cross has already paid for the processing and packaging of the material, and the National Foundation for Infantile Paralysis, through its arrangement with the commercial processors, has purchased the commercial supply at the same rate as that currently supplied defense agencies under governmental contract.

The National Foundation does not have gamma globulin available for distribution, nor will it determine how available supplies shall be used. That is the function of the Office of Defense Mobilization.

Since it has been obvious for some year and a half that gamma globulin would be in short supply, the above plan was agreed upon by all interested agencies, governmental, private and public, to avoid wasteful use of gamma globulin.

* * * * *

## PHYSICIANS NEEDED TO CONDUCT PHYSICAL EXAMINATIONS OF INDUCTEES

The Armed Forces Examining Station, 112 South Gay Street is desirous of obtaining the services of physicians to conduct physical examinations of inductees. The duty would require 2 to 3 hours daily and the rate of pay is $25.00 per day. The station would like to have a list of physicians on whom they may call, the requirements depending entirely on the flow of inductees. General practitioners are desired, but there will be occasional calls for specialists for consultation. It would be possible to give seven to fourteen days notice when the services of a physician are required.

Any physicians interested in this duty should apply to Major R. M. Flynn, Armed Forces Induction Station, 112–114 South Gay Street, Baltimore 2, Maryland.

# Scientific Papers

## *Seminar: Recent Advances in Radiological Studies of the Vascular System**

# AORTOGRAPHY

E. CONVERSE PEIRCE, 2ND, M.D.†

### INTRODUCTION

*Dr. Dotter, members of the panel, ladies and gentlemen:*

It is a great privilege to be here this evening to take part in the discussion of arteriography and angiocardiography. With the permission of the chairman, I have taken the liberty of discussing aortography primarily, by which I mean the contrast visualization of the aorta and its major branches, rather than peripheral arteriography.

Peripheral arteriography was reported first in 1923 in France and Germany and a year later independently by Brooks in this country (1). It is now an established procedure, the technique for which is quite simple. An 18 gauge needle may be inserted into the femoral artery just below the inguinal ligament. Immediately following the injection of 10 cc. of concentrated contrast material two exposures are taken at 5 to 6 second intervals to show the upper and lower levels of the lower extremity. A similar technique is used for the upper extremity and a somewhat longer delay is necessary if pictures of the hands or feet are desired.

By injecting through a larger needle against the blood current it is possible to make satisfactory pictures of vessels as high as the bifurcation of the aorta (2). This, however, is considerably more difficult than making pictures by injecting dye at a higher level as I will explain.

Peripheral arteriography is not much used at the present time because it does not ordinarily provide a diagnosis of the usually quite obvious arterial block. For example it is not usually possible with arteriography to distinguish Buerger's disease from arteriosclerosis obliterans. The principal use of the method is in the evaluation of lesions that can be corrected by surgery such as peripheral aneurysms, arteriovenous fistulas, and femoral arterial blocks that are susceptible of reconstructive surgery. I believe that any of you who find the need for making peripheral arteriograms should feel no hesitation in carrying out the procedure as it is both simple and benign.

With the rapid advances in new surgical methods for treating diseases of the aorta and its larger branches there has been the need for increased use of contrast studies of these structures. In addition aortography has been found useful in the differential diagnosis of renal, adrenal, and retroperitoneal masses, to mention only a few examples. The technique may conveniently be divided into thoracic and abdominal and several methods are available for each.

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Abdominal aortography is particularly useful in the evaluation of obscure renal diseases and has been utilized for such diverse purposes as the evaluation of tuberculosis prior to segmental renal resection (16), the differential diagnosis of cysts and neoplasms, and the diagnosis of aberrant vessels (3, 7). Aortography has been used with great success in a few instances in the localization of adrenal tumors such as pheochromocytoma and cortical adenoma (fig. 1) (6). Retroperitoneal masses frequently cannot be evaluated by the usual methods. The use of aortography with and without retropneumoperitoneum has improved the accuracy of our evaluation (12). The most important use, however, of aortography centers in the diagnosis and minute evaluation of arterial diseases susceptible of surgery including aneurysms, arteriovenous fistulas, and occlusive diseases of the aorta or iliac arteries (fig. 2) (10).

Thoracic aortography is much less widely used but is perhaps even more valuable than abdominal aortography. It is particularly useful in certain complicated forms of congenital heart disease, especially patent ductus arteriosus with atypical murmurs, and coarctation of the aorta, presenting unusual clinical features (fig. 3), which may be either in an atypical location or because of its length require the use of an arterial graft for repair (8). The method also shows promise of



FIG. 1. A four year-old white male with a small left flank mass and precocious sexual development. The aortogram shows an irregular area of increased vascularity above the upper pole of the left kidney which is displaced downward and rotated laterally. At surgery a cortical tumor 7 cm. in diameter was removed through a thoraco lumbar incision. Catheter passed after femoral artery "cut-down," Harriet Lane Home.

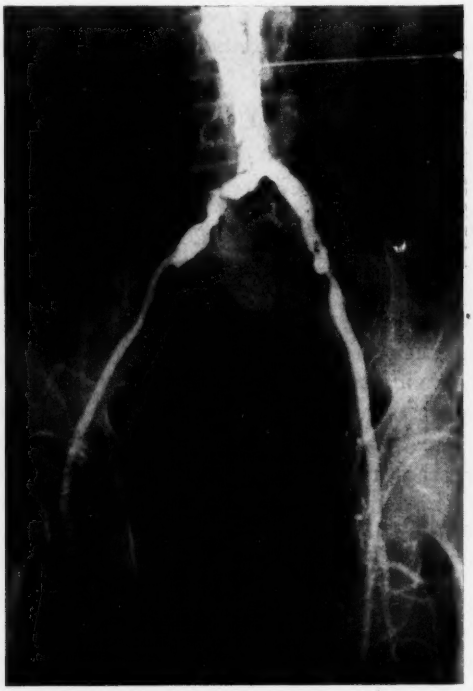


FIG. 2. A 49 year-old white male who had had an endarterectomy in the left iliac region 2 years before for complete occlusion. A low thigh amputation had been necessary on the right following an acute arterial occlusion. There are marked arteriosclerotic changes in the aorta and iliacs. Vascularity is greater on the left. Translumbar arteriogram.

value in other conditions including congenital aortic and subaortic stenosis (fig. 4) and various types of arch malformation. The most common need, however, for thoracic aortography is in the differential diagnosis of aneurysm and neoplasm, and when aneurysm proves to be the disease at



FIG. 3. Coarctation of the aorta in a 40 year-old male. Blood pressures were equal in the upper and lower extremities; there was no rib notching. The patient suffered from episodic hypertension and paroxysmal auricular tachycardia. Percutaneous femoral aortogram shows classical deformity of distal arch and coarctation. Demonstration of the upper segment cannot be relied on by this method.

hand, the method is invaluable in enabling one to determine whether surgery is feasible and if so how it should be carried out (fig. 5).

I will briefly outline the main features of the principal methods of aortography and show examples in the various groups of conditions. There is generally more than one way to show a lesion in a particular location. The methods, however, differ considerably in difficulty, area of application, and quality of the final aortogram and it is necessary to know them all so that the proper one may be chosen in the more complicated cases. Abdominal aortography may be undertaken without great preparation. It is a procedure that is not particularly upsetting to the patient and it



FIG. 4. Probable subaortic stenosis in a 10 year-old child with breathlessness on effort and an extremely loud aortic systolic murmur and thrill. The ascending aorta is very wide and bowed and there is probable subaortic deformity. Angiocardiogram.

is without great risk. Thoracic aortography, however, should not be undertaken lightly as it is relatively difficult and entails the ever possible result of hemiplegia or other serious brain damage (11).

### TRANSLUMBAR AORTOGRAPHY

Aortography of the abdomen was introduced by Dos Santos and his collaborators in 1929 (4). A large needle is directly inserted into the upper

abdominal aorta through the lumbar region. This translumbar method may now be considered a standard procedure. There have been many thousands of satisfactory examinations with only a few mishaps. It is a good method for all abdominal problems and is probably the easiest of all of the aortographic methods (fig. 2) (3, 7).

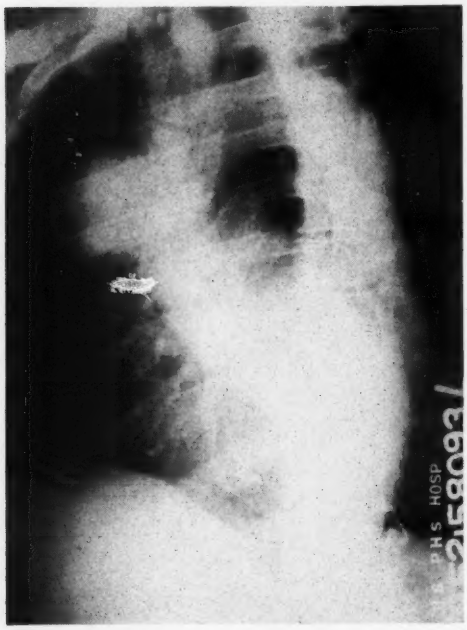



FIG. 5. Syphilitic aneurysm of the ascending aorta in a 47 year-old colored male successfully resected by Dr. Henry Bahnson. Angiocardiogram.

As generally practiced the method is essentially limited to the examination of the abdomen. Placement of the patient is somewhat difficult and it is not always possible to inject the contrast medium in the exact spot desired. Because extravasation of dye occurs occasionally and is extremely painful it is advisable in some patients to use general anesthesia. The method has been used in children but because of difficulty in locating the aorta it is generally not considered very satisfactory.

### ANGIOCARDIOGRAPHY

Angiocardiography, which consists of injecting rapidly a large volume of dye into a vein and following it with serial films during its passage through the heart and great vessels, was introduced in 1939 by Robb and Steinberg (15). This procedure has been of outstanding value primarily for the diagnosis of cardiopulmonary diseases but it also constitutes the easiest method of thoracic aortography (5). It will generally permit satisfactory visualization of the ascending aorta and arch (figs. 4, 5), frequently produces films of diagnostic quality for the descending aorta, and is even rarely useful for the abdomen. It also provides additional useful information in many cases by its passage through the heart and lung.

The equipment for angiocardiography is relatively complicated. Careful timing and serial films are necessary. Unfortunately films of the aorta are generally poorer in quality than those obtained by direct aortography.

### CATHETERIZATION VIA THE BRACHIAL ARTERY

Following the work of Farinas, Radner of Sweden in 1948 described thoracic aortograms of excellent quality obtained by passing a catheter from an artery in the arm into the ascending aorta and injecting dye under pressure (14). This method will produce very satisfactory films of the thoracic aorta in most instances. It is probably the most satisfactory technique for coarctation since angiocardiography frequently produces films too poor in quality, and aortograms made from below the narrowed segment may fail to outline the aorta above the constriction (8).

This method requires an arterial cutdown and it is not always possible to pass the catheter into the aorta. It is technically quite difficult and although it is not considered important, it is generally necessary to sacrifice the radial artery. Using a common radiopaque cardiac catheter it is generally necessary to utilize some type of pressure device to insure rapid enough injection

of dye. The method is practically speaking limited to the thorax and entails the usual danger of cerebral reaction to contrast medium.

### Percutaneous Femoral Catheter Aortography

This method was developed in dogs at the Children's Hospital in Boston and in humans at the Marine Hospital here in Baltimore (10, 12, 13). The procedure is carried out under local anesthesia by inserting a large needle into the femoral artery and passing through it a fairly large bore polyethylene catheter. The catheter tip may be located anywhere from the point of insertion to the aortic valve and good aortograms have been obtained in any portion of the aorta (fig. 3). This has proved to be the most accurate of the abdominal methods and the most versatile of the thoracic methods. Relatively small volumes of contrast material are required. The patient may be positioned as desired and films are obtainable at more than one level. The method has been used successfully in children as young as 2 years.

The major disadvantage is that the method is more difficult and time consuming than translumbar arteriography or angiocardiography. Rarely it is not possible to pass the catheter. It shares with other methods of thoracic aortography the danger of cerebral reaction to contrast medium and should probably not be used in severe occlusive disease of the iliac or femoral artery.

In occasional cases, generally children, in whom percutaneous insertion of the catheter proves too difficult, a femoral arterial cutdown can be utilized. There is probably a real danger of vascular occlusion when this is done, however, and the risk should be carefully weighed before undertaking the procedure (fig. 1).

### Counter Current Aortography Via the Brachial Artery

Although catheter aortography, angiocardiography and translumbar arteriography can be utilized in children in the few instances where information is really needed they are probably not suitable in infants. The method of Keith and Forsyth described in 1950, whereby a small volume of dilute contrast material (3–6 cc.) is injected in retrograde fashion up the left brachial artery into the aorta, will probably give satisfactory aortographic pictures in infants (9). The ascending aorta and arch are frequently not filled. A rapid changer is desirable and somewhat limits the usefulness of the method (fig. 6).



Fig. 6. Normal aortogram ruling out patent ductus arteriosus in infant with severe heart disease requiring use of oxygen tent. Method of Keith and Forsyth. Baltimore City Hospitals.

### Other Methods

A number of other types of aortography and minor modifications of the types mentioned have been described. These are useful in specific instances only.

### Summary

Peripheral arteriography is a relatively simple procedure of limited usefulness. Abdominal aor-

tography is a somewhat more difficult procedure with numerous applications. It can readily be learned by almost anyone. Thoracic aortography is a procedure requiring considerably more skill and involving an appreciable risk. Its use, however, is essential in the proper management of the more complicated thoracic vascular diseases and it should be practiced in all centers dealing with these conditions.

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# ANGIOCARDIOGRAPHY

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Angiocardiography is the contrast roentgenographic study of the heart and great thoracic blood vessels during their opacification by an intravenously injected radio-opaque solution. The technique as it is performed today was perfected by Doctors George P. Robb and Israel Steinberg, in 1937.

The angiocardiographic injection to be successful must be rapid. In practice the full dose of opaque substance (40–50 cc. in an adult) is injected in the total time of 1.5 seconds. Radiographic study of the chest is then made at appropriate or multiple intervals during the passage of the opaque medium through the mediastinal veins, the right heart chambers, the pulmonary circulation, the left heart chambers, and the aorta. In the normal individual approximately ten seconds are required for this cycle to take place.

Angiocardiography produces an unpleasant immediate side reaction consisting of a hot flush, weakness, occasional nausea, and rarely syncope. The subjective reaction is probably least when Urokon is the contrast substance employed.

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In 50 to 75 per cent of cases, a sterile thrombus forms within the injected vein. In our experience these have not given rise to emboli. Although angiocardiography has resulted in a number of deaths—mostly occurring in young patients with congenital heart disease—we have performed two thousand examinations without a fatality. In children the technique should be reserved for cases wherein the findings may be expected to modify the plan of therapy. Its use in the adult for academic purposes is probably justified. The technique of examination is exacting although not difficult. Angiocardiography is a radiologic procedure and should be conducted in the Radiology Department.

### Applications of Angiocardiography

The procedure has proved itself to be of great value in the study of many forms of cardiac, pulmonary and mediastinal disease. Its application to congenital heart disease is well-known and exemplified by coarctation of the aorta and the tetralogy of Fallot. In coarctation, the angiocardiogram can be expected to show the site and nature of the narrowing. This information is of value in planning surgery. It is our belief that angiocardiography (or some other method of contrast study of the aorta) should constitute a routine pre-operative measure in all cases of coarctation of the aorta. It should not be reserved for the "special cases" since physical examination does not allow the examiner to determine which case is a "special case." The physical findings caused by a coarctation low in the thoracic aorta and involving a long narrow segment of the vessel would be identical with those caused by the usual lesion. Figure 1 illustrates the appearance of the latter in a patient who was later successfully operated upon.

It is sometimes necessary to employ additional techniques such as those Dr. Peirce has discussed. Figure 2 illustrates a retrograde abdominal aortogram made in a young girl with coarctation of the abdominal aorta. The angiocardiogram demonstrated the location of the coarctation but was insufficient to outline the detailed vascular relationship.



Fig. 1A

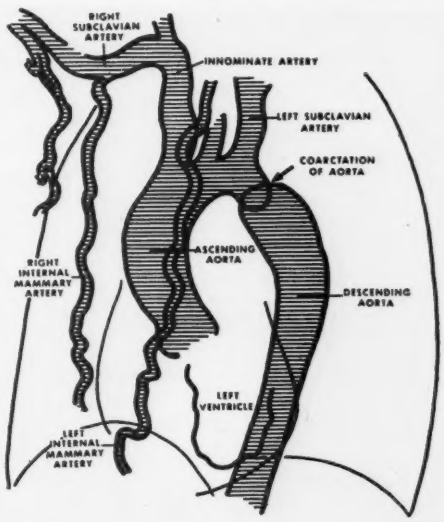



Fig. 1B

Fig. 1. A. *Coarctation of the Thoracic Aorta.* The angiocardiogram shows the site of narrowing to lie a short distance distal to the origin of the left subclavian artery. B. Tracing of A.

In the tetralogy of Fallot and other cyanotic

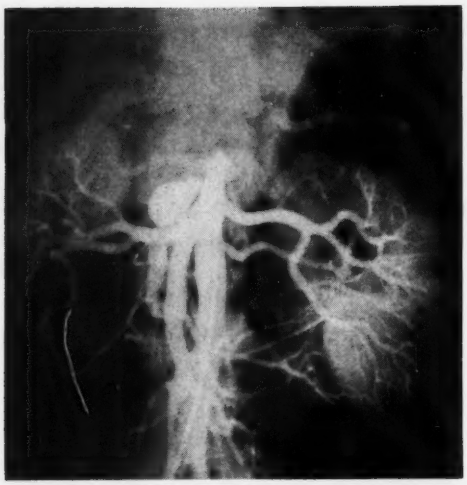


FIG. 2. *Coarctation of Abdominal Aorta.* Retrograde abdominal aortography shows the lower part of an atypical coarctation of the abdominal aorta. Branches of the aorta distal to the coarctation are visualized as is a small aneurysm of the right renal artery.



FIG. 3. *Bullous Emphysema.* Emphysematous bullae have compressed the pulmonary arteries into the basal areas. The vessels are otherwise normal.

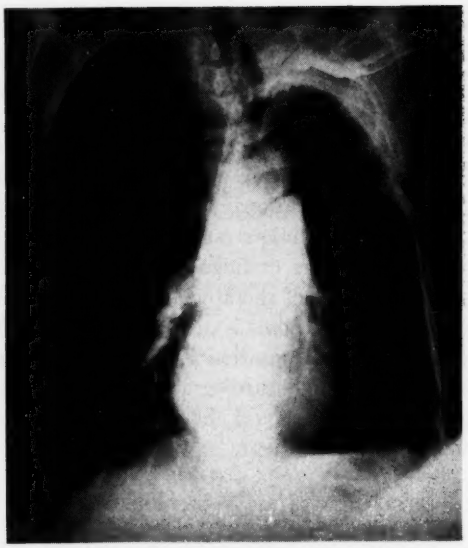


FIG. 4. *Bullous Emphysema, Post Operative.* Following resection of the left upper lobe the vessels to the remaining re-expanded left lower lobe have assumed a more normal appearance. The patient was greatly improved following surgery.



FIG. 5. *Myxoma of the Left Atrium.* A polypoid filling defect caused by the tumor deforms the contrast substance within the left atrium.

congenital cardiac lesions, the physiological abnormality is such as to facilitate examination by angiocardiography. Right-left shunts show up well, the site of shunt representing the origin of the cyanosis. Pulmonary stenosis can frequently be demonstrated either directly or indirectly. We believe that angiocardiography should constitute a routine procedure in the pre-operative

study of patients with cyanotic congenital heart disease.

Carcinoma of the lung frequently produces gross distortion of major pulmonary and mediastinal vessels which cannot be detected by conventional methods of physical examination or roentgen study. Angiocardiography is ideally suited to reveal these changes and therefore contribute to an understanding of the pathologic process present. In approximately 25 per cent of cases studied, angiocardiography will reveal a diagnosis of inoperability and can in some instances obviate need for painful, unproductive surgery. We have studied more than one hundred and fifty proved cases of carcinoma of the lung by means of angiocardiography and feel that this method of examination is of particular value when there is evidence to suggest hilar or mediastinal spread of the neoplasm. Unfortunately, opacification of the pulmonary arteries does very little to aid in the differential diagnosis of round pulmonary parenchymal lesions.

An interesting application of the technique lies in the visualization of distorted pulmonary vessels associated with localized or bullous emphysema. Figure 3 illustrates bilateral upper lobe localized emphysema in a patient who was physically incapacitated due to respiratory insufficiency. Following resection of the cyst of the left upper lobe by Dr. Laurence Miscall, the patient was for the first time in two years able to return to his occupation. The post-operative appearance in this instance is shown in Figure 4, the vascular supply of the remaining left lung having spread out to assume a more normal appearance.

In rheumatic heart disease angiocardiography has provided information of considerable academic value. For example, it has demonstrated that the characteristic changes in *early* mitral stenosis are due almost entirely to enlargement of the left atrium. Where formerly it was believed that enlargement of the right ventricle caused obliteration of the retrosternal space, contrast visualization has shown that this is due to displacement of the right ventricle by an enlarged left atrium. Angiocardiography has shown that the pulmonary conus does not reach the left heart border in frontal projection. It has demonstrated a regurgitant jet deforming opaque substance within the right atrium in patients with tricuspid insufficiency. It has demonstrated thrombi in the left atrium in patients with rheumatic mitral stenosis. Possibly the technique will prove to be of value in the physiologic and anatomic study of patients before and after mitral surgery.

Perhaps the most striking angiocardiographic study in our files is represented by Figure 5. This angiocardiogram—a left heart film—shows an ovoid, irregular filling defect in the mid-portion of the left atrium in a three year old child. The mass proved to be an intra-atrial myxoma. We have seen two other cases such as this and in all three cases the pre-operative or pre-mortem diagnosis of intra-cardiac myxoma was correctly made.

It has not been our intention tonight to attempt to cover the field completely. The different techniques about which you have heard include angiocardiography, cerebral angiography (as presented by Dr. Chambers), and aortography (as presented by Dr. Peirce). These techniques have considerably expanded the field of diagnostic radiology in the study of cardiovascular lesions. It has been a pleasure for the members of this panel to meet with you here in Baltimore and we encourage any of you to ask us questions.

# CYSTIC FIBROSIS OF THE PANCREAS*

GORDON E. GIBBS, PH.D., M.D.†

## CLINICAL MANIFESTATIONS

The main symptoms of cystic fibrosis of the pancreas are chronic cough and mild diarrhea. Since the clinical findings also occur in more common conditions, this diagnosis is frequently overlooked. In the newborn period, the disease may appear as intestinal obstruction in one of the forms of meconium ileus. When the onset is later, the initial symptom may be digestive or respiratory. The digestive deficiency is manifested by poor weight gain; foul, bulky, soft stools (steatorrhea); wasted musculature; increased appetite; and enlargement of the abdomen. The respiratory component progresses to bronchiectasis, bronchopneumonia, and death. Even at autopsy, the diagnosis is frequently missed. The pancreas may appear grossly normal, the marked pathological changes being definite only in microscopic sections. Most cases become manifest in infancy.

## ETIOLOGY

The fundamental pathogenesis of the disease remains to be elucidated. A prominent theory is that a defect of mucin metabolism exists, whereby, small tubules, particularly of the pancreas and lungs, become obstructed with mucoid materials. The abnormality could be:

1. an abnormal structure of the mucin
2. a deficiency in the liquefying mechanism
3. abnormal autonomic control of mucin secretion

The general mucin hypothesis is supported by the viscosity of the duodenal aspirate and by the engorgement of bronchial, duodenal and other mucous glands. The name "mucoviscidosis" has been proposed for this disease.[1] A similarity of the bronchial mucous glands to those seen in asthma has been considered to detract from the "mucoviscidosis" hypothesis.[2] Moreover, the increased viscosity of the duodenal aspirate (containing mucus from Brunner's glands, etc.) would seem at least partially accounted for by absence of the water and trypsin normally contributed by the pancreas.

In an attempt to find further evidence of a primary defect of mucin metabolism, studies of serum beta glucuronidase and of serum mucoprotein are nearing completion at the University of Maryland. These studies have failed to reveal any significant abnormality in concentrations of these particular substances. Further explorations of other aspects of metabolism of mucopolysaccharide derivatives are in progress.

The metaplasia of bronchial mucosa may be secondary to chronic infection, but also simulates the effects of vitamin A deficiency, giving rise to suspicion that lack of this vitamin might be involved in the primary etiology. While attempts at therapy and prophylaxis with vitamin A have been disappointing, there is no doubt that clinical vitamin A deficiency has often occurred secondarily in cystic fibrosis of the pancreas, particularly before the days of liberal vitamin A supplementation. The possibility that some other nutritional factor might be of specific etiological importance, of course, remains.[2]

## SIMPLE OFFICE TESTS

The typical case shows excess fat in the stools observed microscopically with Sudan III. This test may fail to show excess fat if the diet is low in fat or if the pancreatic deficiency is incomplete. On the other hand, conditions such as celiac disease and intestinal allergy may also give steatorrhea.

Another simple test of pancreatic function is

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the proteolytic action of a fecal suspension on the gelation of x-ray film.[3] Various more elaborate procedures for this test are in use, but the following specifications are designed to be so simple as to be performed conveniently by any physician with a minimum of equipment. A 1:10 suspension of stool in tap water is left on a piece of x-ray film for 90 minutes at room temperature. The suspension is then washed off with a stream of cold water. After drying, the translucency of the area is noted. This test may be confused by:

1. use of stale stool
2. incomplete pancreatic deficiency
3. unreactive type of x-ray film
4. transient pancreatic deficiency associated with other conditions
5. bacterial proteolytic enzymes[4]

The latter difficulty is most likely to occur if the patient has been on vigorous antibiotic therapy. When the hazards of interpretation are kept in mind, these simple tests have a degree of usefulness. However, a definite diagnosis of cystic fibrosis of the pancreas is rarely, if ever, justified without a satisfactorily conducted duodenal drainage.

### Diagnostic Hospital Procedures

The most reliable diagnostic data come from duodenal drainage. While use of a single lumen tube often gives conclusive results, use of a double lumen tube for simultaneous gastric and duodenal aspiration has been found advantageous in several pediatric centers.[5, 6, 7] Use of the two single tubes has also been found practical.[5b, 8] Simultaneous gastric and duodenal drainage help to minimize contamination of the duodenal specimen by gastric fluid, a difficulty which has been very troublesome when duodenal drainage alone has been done.

The double lumen gastroduodenal tube previously described by the present writer was of 12 French diameter.[5] Recently, a larger, 14 French, tube has been used. (The tubing used in a 14F Miller-Abbot tube is satisfactory.) This tube largely avoids the difficulty of plugging which was sometimes troublesome in the smaller tube. It seems to pass the pylorus approximately as readily. A solid gold tip of the same diameter as the tubes and weighing 3.5 gm. has been used. This tip permits the tube to be passed nasally, as is convenient in older infants with teeth. A rubber bag (finger cot or Cantor tip) with 10 to 15 grams of mercury has also been used with consistent success. The bag is less convenient to pass through the nose. The value of weighting of the tip is a subject of dispute awaiting collection of additional quantitative data.

Fluoroscopic verification of the position of the tube is desirable. However, when alkaline, clear, yellow fluid comes consistently from the duodenal tube, while colorless, turbid, acetic fluid comes from the gastric, there can be little doubt of the correct position of the tube. Testing the duodenal aspirate for trypsin by means of x-ray film often gives information regarding the position of the tube. Normal juice produces partial clearing in 5 to 15 minutes at room temperature.

For evaluation of pancreatic function, the volume, alkalinity and enzyme content of the juice are useful. Stimulation of the pancreas by the hormone secretin[5a, 9] increases the significance of the volume and alkalinity determinations. Trypsin is the pancreatic enzyme most useful in the infant, amylase levels normally being low during the first few months. In our laboratory, trypsin is measured by the Anson method, which determines, colorimetrically, the tyrosine liberated from a hemoglobin substrate. Most clinical laboratories use other chemical procedures for trypsin estimations. At least one laboratory determines the viscosity of the duodenal aspirate.[10]

Tests involving digestion of vitamin A ester[11] or of protein[12, 13] have been useful in various laboratories.

### Incomplete Pancreatic Deficiency

Diagnosis of the disease is rendered difficult in some instances by lack of completeness of the pancreatic deficiency.[14] In such cases, the pul-

monary component of the disease may be of full severity. The most refined technique of duodenal drainage is needed for attempts to establish the diagnosis in such cases. Even such technique may be indecisive at times.

## Treatment

Treatment is directed against the pancreatic deficiency and the pulmonary infection. Pancreatin, high protein (low fat) diet, and vitamin supplements form the nutritional approach.

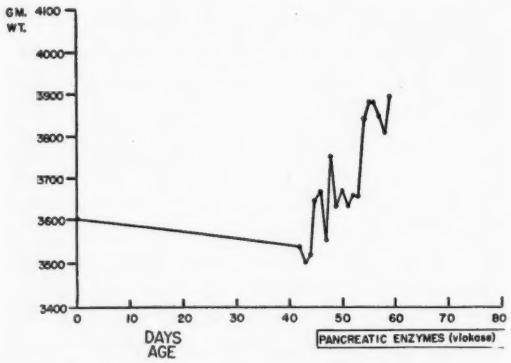



Fig. 1. The effect of pancreatin on weight gain

Their use probably favors the achievement of optimal results from the antibiotic therapy of the pulmonary infection. In the experience of this observer, use of pancreatin of adequate quality and quantity has quite regularly been followed by nutritional improvement as evidenced by weight gain and firmer stools. The exceptions have been cases with severe pulmonary infection resistant to antibiotics. Figure 1 illustrates one of the cases in which no significant change of therapy was used other than administration of pancreatin to cause the sudden weight gain. The child has had numerous upper respiratory infections since. Various antibiotics have been used, but only for short periods to terminate the bronchitis at the end of these infections. At the age of two years, she has no chronic cough, her chest x-ray is clear, and she is of average, normal size and weight.

In various cases, we have used penicillin, streptomycin, Terramycin, Aureomycin, chloramphenicol, bacitracin, neomycin, polymyxin and sulfonamides. Choice of drugs has been guided somewhat by in vitro sensitivities. Survival of these cases, usually, becomes a race between the acquisition of drug resistant organisms and the availability of new antibiotics. Drug resistant strains of Staphylococcus aureus and Pseudomonas aeruginosa are the usual problems in advanced cases. Bacitracin and acetic acid respectively have shown some promise, used by aerosol against these two organisms. Continuous use of broad spectrum antibiotics for prophylactic or suppressive effect is currently in vogue in some centers.[10] Whether such a regime improves the results to be obtained from prompt and vigorous treatment with appropriate antibiotics at times of respiratory infections remains to be proven.

Various agents by aerosol to promote liquefaction of bronchial secretions are under trial. This approach may prove to be a fundamental one in the pulmonary problem.

## Prognosis

Survival in most cases has been limited by pulmonary infection and acquisition of drug resistant organisms. The tendency to bronchitis varies from case to case. Two patients are known to have lived 17 years, during much of which time they did not have the benefit of modern antibiotics. With the development of new means of therapy, the life expectancy has improved to an extent which no one can now assess.

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# USES AND MISUSES OF ANTIBIOTICS IN SKIN DISEASES*

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One of the more important recent advances in the treatment of disease has been the advent of potent chemotherapeutic and antibiotic drugs. Just as in other branches of medicine, the antibiotics have an important role in the treatment of cutaneous diseases.

At the Department of Dermatology of the University of Maryland School of Medicine, a team of four experienced clinicians has been investigating the benefits and disadvantages of various chemotherapeutic agents employed both systemically and topically in the treatment of diseases of the skin. The team approach has been used in order to promote objectivity in the evaluation of the effectiveness of the drugs.[1]

## BACTERIAL DISEASES

The common dermatoses of bacterial etiology are those caused by staphylococci and streptococci. Since these microorganisms are usually susceptible to chemotherapy, the antibiotics are particularly useful in cutaneous diseases caused by them. Impetigo, ecthyma, folliculitis, furuncles, carbuncles, sycosis vulgaris, cellulitis and erysipelas are treated successfully with these agents. In addition many skin disorders of other or unknown cause may become secondarily infected by these organisms. Thus fungous infections, atopic dermatitis, contact dermatitis, and seborrheic dermatitis not infrequently become secondarily impetiginized and it is imperative to treat the superimposed infection first before any attempt is made to favorably manage the primary disease. Antibiotics usually successfully clear such secondary infections.

The choice of antibiotic is at times very important. Bacterial resistance is particularly important in the treatment of patients infected with pathogenic strains of staphylococcus aureus. During the past ten years those strains which form penicillinase have become dominant in producing infections. The fact that the majority of strains of disease producing staphylococci are resistant to the antibacterial effects of penicillin should be borne in mind by all physicians.[2] Resistance of gram-positive cocci to aureomycin, chloromycetin and terramycin also occurs at times, but is not now as pressing a problem as that due to penicillin. Generally speaking, the broad-spectrum antibiotics, as well as erythromycin, bacitracin and neomycin are today effective in the treatment of staphylococcal diseases of the skin. At times tests for the sensitivity of micro-organisms to antibiotics should be used, but these are subject to varying interpretations. In actual practice, such tests are indicated when the antibiotic selected for use seems ineffective, and not as a routine measure for choosing the antibiotic for therapy.

Thus today in staphylococcal infections of the skin, if systemic therapy is to be employed, peni-

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cillin is not always the antibiotic of choice. In streptococcal infections, however, penicillin is usually the most effective agent, though the broad-spectrum antibiotics are also effective.

Pseudomonas pyocyaneus infections in otitis externa are greatly benefitted by polymyxin dropped into the external auditory canal. Chancroid, caused by the Ducrey bacillus, is effectively treated by aureomycin, terramycin and chloromycetin but in our opinion the sulfonamides represent the treatment of choice because they are not spirochetocidal and hence do not mask early syphilis. Distinct advances have recently been achieved in the treatment of the many manifestations of cutaneous tuberculosis. Amongst others, streptomycin administered systemically and also injected locally is very helpful.

### Fungous Infections

The antibiotics are not effective in the treatment of superficial fungous infections of the skin per se but are very beneficial in clearing the secondary staphylococcal and/or streptococcal superinfection in cases of tinea circinata, tinea capitis, tinea cruris and in dermatophytosis and dermatophytid. Though much has been written about the dangers in the use of penicillin and other antibiotics in the treatment of dermatophytid, we have rarely seen instances of dermatophytid exacerbated by antibiotics including penicillin, and in fact advocate their use in secondarily infected dermatophytosis and dermatophytid.

One of the important contraindications and dangers in the use of the broad-spectrum antibiotics is monilial infection. As is well recognized, candida albicans thrives when aureomycin, terramycin and chloromycetin are administered with the production of perleche, glossitis, stomatitis, nausea, vomiting, diarrhea, perianal and perivulvar dermatitis and other pruritic eruptions. Neomycin applied topically not infrequently produces eruptions from which candida albicans can be cultured.[3]

The effect of the antibiotics on the deep fungous infections of actinomycosis, blastomycosis, sporotrichosis and coccidioidomycosis appears to be inconstant with various combinations at times successfully employed.

### Parasitic Diseases

Syphilis has been struck what appears to be a severe blow since the advent of penicillin. Various regimes are employed but generally speaking, six million units are given for early syphilis and from six to twenty million for various manifestations of late syphilis. In the usual doses employed, streptomycin appears to be non-spirochetocidal, but aureomycin, terramycin, chloromycetin and erythromycin are anti-syphilitic drugs, though their ideal dosages are still not determined.

The antibiotics materially speed recovery from the staphylococcal and streptococcal infections superimposed on a scabetic infestation.

### Viral Diseases

These chemotherapeutic agents are helpful in combating the secondary infection superimposed on herpes simplex and on herpes zoster. Not infrequently the broad-spectrum antibiotics stop the pain of herpes zoster but they do not prevent postzosteriform pain.

There have been a few individual case reports on the treatment of molluscum contagiosum but we have observed no benefit from the administration of any of the antibiotics in this disease.

Lymphogranuloma venereum is benefitted by the broad-spectrum antibiotics but the acute phase is probably best handled by the sulfonamides because of their non-spirochetocidal effect. Rectal stricture has recently been reported to be materially aided by these antibiotics.

We have been particularly impressed with the effect of chloromycetin and of erythromycin on granuloma inguinale. At times, these ulcerative lesions of ten or more years duration completely heal within two to three weeks. Aureomycin, terramycin and streptomycin are also beneficial

but do not produce nearly so dramatic a cure and are not infrequently attended by relapses.

### Allergic Diseases

Erythema multiforme bullosum is frequently but not always favorably affected by the systemic administration of penicillin, aureomycin, terramycin or chloromycetin. Whether the antibiotics affect the secondary infection of the bullae or the affection per se is undetermined. We have not been impressed with the beneficial results in erythema nodosum, nor is urticaria usually improved with antibiotics.

Neither contact dermatitis nor atopic dermatitis is basically affected by antibiotics but the secondary pyodermic infection of these allergic eruptions is markedly improved by them.

### Endocrine Diseases

Similarly seborrheic dermatitis is not improved by these chemotherapeutic agents, but when there is secondary impetiginization, they are particularly helpful and accelerate good management of the eruption.

The pustular and cystic types of acne are aided by the administration of antibiotics, but upon withdrawal of these drugs, the eruption frequently relapses.

### Inflammatory Diseases of Unknown Etiology

Lichen planus, psoriasis and pityriasis rosea are not particularly helped by antibiotics. At times, pemphigus vulgaris is improved with systemic administration, but today the steroid hormones are the treatment of choice. The systemic and localized forms of lupus erythematosus and of scleroderma are not benefitted by these drugs.

### Systemic versus Topical Therapy

In the treatment of primary or secondary pyodermas, the antibiotics are helpful when administered both systemically or topically. For localized areas, topical treatment is more practical but for widespread or generalized or deep pyodermas, systemic administration is recommended. This is especially important when one considers that the skin from widespread cases of pyoderma is the portal of entry in many cases of glomerulonephritis.[4]

Obviously any of these drugs administered systemically is a potential allergen and when it is known that a patient has manifested an allergic reaction in the past or an undesirable side-effect, another antibiotic should be employed. As to topical therapy, penicillin, streptomycin and chloromycetin are such potent sensitizers when applied to the skin, that they should not be used locally.

### Recapitulation

1. The antibiotics are indicated in the treatment of primary and secondary pyodermas; many skin staphylococci are not now penicillin-sensitive so that other antibiotics must frequently be employed.
2. Penicillin is not necessarily interdicted in the treatment of secondarily infected dermatophytosis and dermatophytid.
3. Penicillin is the chemotherapeutic agent of choice in the treatment of syphilis.
4. Chloromycetin and erythromycin give dramatically gratifying results in the treatment of granuloma inguinale.
5. Erythema multiforme frequently responds to the administration of antibiotics.
6. Most other cutaneous diseases are not benefitted by the administration of antibiotics or are only temporarily or inconstantly helped.
7. For pyodermas, antibiotics should be administered systemically for widespread and deep involvement and topically for localized involvement.
8. Antibiotics may cause undesirable side-effects or allergic reactions; because of their high skin sensitizing indices, penicillin, streptomycin and chloromycetin should not be employed topically.

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## DUAL REGISTRANTS HAVE 30 DAYS TO ASK RESERVE COMMISSIONS

The AMA Washington Letter, No. 43

Selective Service has instructed local draft boards to give physicians registered both under the regular doctor drafts 30 days in which to make application for a reserve commission, once they are called up. The agency said applicants, in applying on a form supplied by their boards, may indicate their first and second choice of service. Selective Service adds that the military department involved will notify the state director of Selective Service of any registrant who doesn't accept a commission within 30 days after it is tendered. Such registrants would then face early induction as privates.

The new instructions follow the October 8 master directive of the Defense Department implementing the revised doctor draft last June. The directive, among other things, clarified the status of doctors with dual responsibility, and the Selective Service instructions completed the picture. Selective Service Director Lewis B. Hershey commented: "It is the policy of the armed forces to utilize in a commissioned rather than enlisted status all special registrants who qualify for such commissions. This headquarters concurs in that policy."

## NSF MAKES 15 GRANTS IN MEDICAL FIELDS

The AMA Washington Letter, No. 43

More than 10% of the National Science Foundation awards announced so far for fiscal 1954 are of interest to the medical profession. Of the 123 awards for $1,332,000, fifteen grants totaling $201,300 are in medical or allied fields. They average 2.4 years $13,420 each as compared with an average 1.8 years and $10,828 each for the entire group. Some medically significant work to be done under these NSF grants include research on amino acid metabolism, physiological development of regulatory functions, glucose penetration into cells, x-ray studies of viruses, and hydrodynamic properties of proteins. Additional grant proposals are being studied and NSF decisions will be announced later.

# Component Medical Societies

## ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

*Journal Representative*

The following articles appeared in the Cumberland Evening Times:

### Knowing Own Blood Type Important

The medical director of Civil Defense for Allegany County has issued an appeal for all persons to have their blood typed.

Dr. Leslie E. Daugherty, director, said that information would save many lives in event of an attack by an enemy. He added that 44 per cent of Allegany County citizens have type O and 66 per cent other types. When a person knows his blood type, he should carry a note of it with him constantly.

### Medical Care Waiting List Exceeds 400

Allegany County Medical Care waiting lists—which recently stood at the 427 mark—have ranged from 300 to more than 400 since the quota system was adopted by the State Board of Health.

The adoption of the quota system followed a cut in state appropriations to provide medical care for those who cannot afford to pay for it.

In this County, it means that only 2,402 persons were authorized to receive free medical and dental care at one time.

*To Meet Emergencies*

However, when the system was adopted, provisions were made to take care of emergency cases, so that those in dire need of medical attention and drugs would not suffer. Officials believe such needs are being met.

Medical care is provided by the state for two groups—those who are receiving assistance from the Allegany County Welfare Board, and the medically indigent. The last group includes persons who have some income but are unable to make it stretch to meet the costs of medical attention.

Early in August, the Allegany County Health Department stopped issuing new Medical Care cards until the rolls dropped to the 2,402 mark.

Nobody was dropped from the program, but as six-month authorizations expired, persons were placed on the waiting list.

*Will Mail Cards*

When the quota allows, new authorizations are mailed to the persons on the top of the waiting lists.

New applicants are placed on the list after renewals and will be issued cards as their names come up.

Dr. Winter R. Frantz, county health officer, said that except in cases of emergencies, it is useless to contact the Health Department about Medical Care cards, since they are issued and mailed automatically whenever the quota drops to the 2,402 mark.

The state has allotted $93,313 for Medical Care costs in Allegany County this year, estimating that 2,402 persons can be given medical care at an average cost of $38.02.

Last year, when $101,051 was spent for the program here, average enrollment was 2,658.

The following articles appeared in the Cumberland Evening Times:

### Dr. Frantz Commends Work of County Lay Health Group

Dr. Winter R. Frantz, county health officer, was the speaker at a recent meeting of the Allegany County Public Lay Health Council in the Union Street County Building. Miss Mary Margaret Smith, R. N., presided and introduced Dr. Frantz.

Dr. Frantz commended the council for its work and cooperation with the Health Department. He stated 520 clinics are held by the Health Department each month and that lay assistance is given at nearly all of them.

Speaking on the topic, "Public Health," Dr. Frantz stated "More people are becoming health conscious due to public education."

Mrs. Elizabeth Nave, Mrs. Charles Heller and Mrs. Lester McGill were named to the nominating committee to select a slate of officers to be elected at the November meeting.

Reports were given by the various group chairmen including Mrs. Albert Snelson, Corriganville; Mrs. Nave, City; Mrs. Cecelia Edmondson, South Cumberland; Miss Smith, LaVale, and Mrs. Lester McGill, Cresaptown.

The following committee was named to plan a Christmas party: Mrs. Patrick Allender, Chairman; Mrs. Heller, Mrs. Edmondson, Mrs. Nave, Mrs. Snelson, Mrs. McGill, Miss Smith, Mrs. Thomas Williamson, Mrs. Helen Bogel, Mrs. Martha Hamilton and Mrs. Leila Vandegrift.

Health nurses will be hostesses to the workers at the November meeting.

### Student Nurses to Take Training

A week of training in public health nursing will be given senior students of Memorial and Sacred Heart Hospitals by the Allegany County Health Department.

Dr. Winter R. Frantz, city and county health officer, said the 1953–54 program will start soon, when two student nurses from Memorial Hospital will be assigned to the department for a week.

The training for Memorial Hospital students will continue through January.

Similar field training for students at Sacred Heart School of Nursing will begin in February.

Dr. L. I. Brings, Cumberland, Dr. Martin M. Rothstein, Frostburg; Dr. E. Irving Baumgartner and Dr. Thomas F. Lusby, II both of Oakland, and Dr. Milton Tepfer, of Friendsville, attended the fifth annual scientific assembly of the Maryland Academy and General Practice at the Lord Baltimore Hotel, Baltimore, on Wednesday, October 21.

Allegany County Medical Director of Civil Defense has issued an appeal for all persons to have their blood typed.

### Allegany County Physicians Participate in State-Wide Air Alert

During the recent statewide air alert, six Casualty Clearing Station medical directors had reported within three minutes of the first alarm that they were standing by for mobilization. All key posts were alerted and ready to act when the all-clear signal came.

Allegany County has six complete stations and the following physicians serve as directors; Dr. O. R. Roth, Dr. Clay Durrett, Dr. Leland Ransom, Dr. Leo H. Ley, Jr. of Cumberland and in Frostburg, Dr. Martin M. Rothstein, and at Westernport, Dr. J. Norman Reeves. The chief medical director of Civil Defense for Allegany County is Dr. Leslie E. Daugherty, of Cumberland.

Student nurses now receive training in public health work with the Allegany County Health Department.

## BALTIMORE CITY MEDICAL SOCIETY

CONRAD ACTON, M.D.

*Journal Representative*

Plans for the 1953–54 monthly meetings are crystallizing. The final programs will be distributed soon. The December, "President's Meeting," will be on tuberculosis. President Fort has arranged an all-out review featuring experts from Denver, Trudeau, Philadelphia, New York City, and Baltimore who will give us the best and most advanced tactics in the attack on the white plague. Baltimore's new Veteran's Administration Tuberculosis Hospital will co-sponsor the program. It will have the endorsement of State and National Tuberculosis organizations.

Programs for next year will not all be of the panel type. A reversion to lectures and case presentation is planned for the January Meeting on regional enteritis and "ulcerative colitis," according to Doctor Arthur Weinberg, chairman of the Program Committee.

President Fort's innovation: suggestions from the general membership to the Nominating Committee concerning officers for the coming year, will bear fruit this month. Will the idea be so startling that no one takes it too seriously? Will it be so welcome that the committee is swamped? Will it be an effective step away from the "Wheel-horse"-type of operation of this Society with two thousand members and one hundred voters at meetings?

The Committee on Postgraduate Courses probably will report the complete statistics returned on their questionnaire. Chairman Harry M. Robinson, Jr., divulges that in the month after two thousand inquiries were sent out there were over six hundred

replies. Very few were critical, most were helpful. Nearly six hundred wanted the postgraduate courses continued. The general desire, was for more than one short course during the winter.

In response to the requests, four courses have been arranged for the January-April period. It is regrettable that at least one could not have been held during President Fort's term of office because of his effective interest in getting them started. Of the four that led the poll, "Fluid Balance" will be given in April, Dermatology in January, Hematology and Endocrinology in February. Lecture-demonstration will be the chief form of presentation.

These postgraduate courses have aroused interest in areas outside the city. Chairman Robinson and President Fort feel that this is strictly a Baltimore City Medical activity, free to all members, for whom it is primarily intended. Other physicians are welcome as guests. There is no intention nor desire to interfere or conflict with the University of Maryland Medical School's Committee on Postgraduate Studies headed by Doctors Howard Bubert and John Wagner and their extensive staff.

## CANCER SECTION

ARTHUR G. SIWINSKI, M.D., *Secretary**

The meeting of the Cancer Section of the Baltimore City Medical Society was held on the 14th of October 1953 at Bethesda, Maryland. The section were the guests of the National Cancer Institute. Thirty-eight members gathered at the Officers Club of the Navy Medical Center at 6:00 p.m. Dr. Seager made arrangements for a very tasty meal which all enjoyed. After the dinner the group prepared to go to the new clinical center of the National Cancer Institute where we were joined by about twelve members who had been unable to attend the dinner.

Dr. Seager and Dr. John R. Heller, Jr. then conducted the group through part of the building to give us an idea of their set-up. Everyone was much impressed with the well equipped patient's rooms, and the excellent facilities for laboratory investigation. After this the entire group gathered in the fourteenth floor for the scientific session. The meeting was called to order by Dr. Edwin H. Stewart, Jr. at 8:25 p.m. After thanking our hosts for making such nice arrangements for us Dr. Stewart turned the meeting over to Dr. Burroughs Mider.

In a few words Dr. Mider outlined what was expected to be accomplished in the center and then introduced Dr. Robert Smith the Chief Surgeon. Dr. Smith gave us a brief outline of the clinical program of investigation which his section will in the future attempt. At the present time Dr. Smith states that the current interest is in pelvic and head and neck problems. Dr. Edward F. Lewison asked if there were any formal mechanism for the admission of patients to the center. Dr. Smith and Dr. Heller answered this question stating at present there is no formal mechanism and that contacts be on a personal basis. He stated, however, that if the group so desired a regular mechanism could be set up.

Dr. Mider then introduced Dr. Roy Hertz. Dr. Hertz discussed briefly the endocrine factors which play a part in the treatment of carcinoma of the prostate and their possible mode of action. He then went on to discuss the relationship of folic acid and biotin.

The meeting adjourned at 9:55 p.m.

* Cancer Section, Baltimore City Medical Society.

## FREDERICK COUNTY MEDICAL SOCIETY

JESSE S. FIFER, M.D.

*Journal Representative*

### RIGGS COTTAGE SANITARIUM CHANGES HANDS

The Riggs Sanitarium at Ijamsville, Frederick County, in continuous operation for the treatment of nervous and mental patients, since its inception in 1896, has been sold by Dr. McAdoo to Dr. Joseph Lerner of Devan, Pennsylvania. Dr. Lerner took over the operation of the institution on October 1, 1953.

Doctor McAdoo and his wife, Dr. Julia Kagen, are retiring on their ranch in the Ozark Mountains for a period of one year. In the meantime, they will decide whether or not and where they will resume the practice of neuropsychiatry.

Dr. Joseph Lerner, the new owner of the institution has a background of many years of training

and varied experience, in the field of neuropsychiatry. He is a diplomate of the American Board of Psychiatry and Neurology. Mrs. Lerner is a graduate of the Jefferson Medical College Hospital Training School.

Dr. George Henry Riggs, founder of the Riggs Sanitarium, was born at Ijamsville in 1870 and was graduated from the University of Maryland, School of Medicine in 1891. For about five years he was on the staff at the Conrad's Sanitarium at Relay, Maryland, the first private institution in the State for nervous and mental diseases.

Dr. Riggs then returned to his native community and established the Riggs Sanitarium for the treatment of nervous and mental patients. In 1939, Dr. Riggs sold the institution to Dr. McAdoo, but continued the practice of medicine in the county for a total of sixty years. He is now retired and lives with a daughter, Mrs. England, at Arlington, Virginia.

The Riggs Sanitarium has a patient capacity of about thirty and has been devoted exclusively to the treatment of the nervous and mentally ill patients for which it is well adapted by its inviting environment, on a beautiful lawn with gardens and a forty-two acre farm, a small quiet hamlet and a picturesque country side.

The McAdoos won the love and respect of their fellow physicians in Frederick County during their stay here. In their honor and as a farewell to them, Dr. and Mrs. Byron D. White gave a party at their home on Rockwell Terrace on September 23rd, to which 18 physicians and their wives were invited. The McAdoos left for their home in the west October 1st, with best wishes of the members of the Frederick County Medical Society.

## PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

J. M. WARREN, M.D.

*Journal Representative*

The Prince George's County Medical Society devoted its October meeting to Civil Defense. Dr. Welch, who has charge of the State Civil Defense Program, addressed the society and discussed the great need for an active Civil Defense Program in the County. The doctors in the County have been organized through Dr. Brainin's committee, each one being assigned to a hospital unit or to a casualty clearing station. We are encouraging the doctors to study emergency medical treatment and help train non-professional personnel in the various casualty clearing station groups.

Dr. Moyers, reporting from the Maryland Medical and Chirurgical meeting spoke of the need for increased medical dues. He alluded to the fact that the Federal Government may try to assume the responsibility for the medical care of all veterans and their families some time in the near future. We feel that this is just another step towards socializing medicine, and hope that our organization will fight to prevent it.

Our November meeting will be devoted to a banquet and dance to be held at the Statler Hotel in Washington. This program will be under the supervision of Frederick Musser and his entertainment committee. This was well attended last year and a good time was had by all. We hope to have even a better attendance this year.

## WICOMICO COUNTY MEDICAL SOCIETY

WILBER R. ELLIS, JR., M.D.

*Secretary-Treasurer*

The first fall meeting of the Wicomico County Medical Society was held at 8:30 p.m., on October 12, 1953, in Salisbury, Maryland. Through the efforts of Dr. Alfred S. Ledermann of this Society, a very complete symposium on psychiatry was held. The following was the program:

I. *Mental Illness and the Community.* George F. Sutherland, M.D., Chief, Division of Psychiatric Education and Training, Department of Mental Hygiene, State of Maryland, and Associate Professor of Psychiatry, Duke University School of Medicine, and Earl K. Holt, M.D., Assistant Commissioner, Department of Mental Health, State of Maryland.

II. *Principles of Treatment of the Patient in a Private Psychiatric Hospital.* Irving J. Taylor,

M.D., Medical Director, Pinel Clinic, Ellicott City, Maryland.

III. *Schizophrenia.* George Currier, M.D., Superintendent, Eastern Shore State Hospital, Cambridge, Maryland.

IV. *Psychosomatics.* Louis Krause, M.D., Professor of Medicine, University of Maryland School of Medicine, Baltimore, Maryland.

There was a large attendance made up of local physicians, members of surrounding counties of Maryland, and physicians from nearby counties of Delaware and Virginia.

Members of the Society wish to thank Dr. Ledermann and his guest speakers for a very interesting and informative program.

## DEFENSE DEPARTMENT ISSUES DIRECTIVE ON REVISED DOCTOR DRAFT

The AMA Washington Letter, No. 41

With the issuance October 8 of Defense Department's directive to implement the revised doctor draft act, the three military services are prepared to put into effect all changes called for by the new law. The directive has been more than three months in preparation. Pending its official release, Army, Navy, and Air Force have delayed acting on a number of things, including the upward adjustment in grade for certain officers.

The directives restates much policy that has been in effect for some time, but also makes the following new points:

*GRADE:* The law requires appointment, reappointment, or promotion to a grade "commensurate with professional education, experience or ability." The directive retains the present scale of grades, based on years of experience, and states that promotions must be given "at the earliest practicable date" to men now on active duty who qualify for higher grades. In effect, this means that a physician's experience alone will determine the grade in which he serves, whether he is on active duty now or is commissioned or recalled in the future. Eliminated are such limiting factors as shortage of higher grades in a table of organization, the arbitrary commissioning of Priority I and II men on the basis of cutoff dates, and delays pending action of officers' boards. (The following scale is used to determine grades: if less than four years' professional experience since graduation, first lieutenant; four but less than 11 years, captain; 11 but less than 18, major; 18 or more, lt. colonel; comparable grades in the Navy.)

## NEW INVESTIGATIVE OPPORTUNITIES FOR MILITARY PATHOLOGISTS

The AMA Washington Letter, No. 43

The $7 million Armed Forces Institute of Pathology, whose cornerstone was laid October 20, will offer pathologists of the three services an opportunity to expand their work under ideal conditions. Available to them now will be investigative laboratories in the basic sciences, whereas in the old building they were mostly limited to studies in morphologic pathology. The outside structure is like a one-piece concrete box, one of the few buildings in the country designed to resist atomic bombs. Inside, the flexible design makes use of demountable steel partitions. The building will be completely equipped with an intercom or "squawker" system, and numerous television outlets will make an autopsy visible to any number of observers. Color television connects the operating rooms at Walter Reed hospital with the Institute's labs, giving the surgeon and the pathologist an opportunity to follow each other's activities. Pneumatic tubes will carry specimens directly from operating rooms to labs.

# Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

## ARTHRITIS

LOUIS KRAUSE, M.D.*

Arthritis is a condition that goes back to time immemorial. The skeletal remains of earliest Egypt give evidence of the presence of this disease at that time. I can testify to this myself as a result of my observations of the mummies recovered from the many ancient graveyards in Egypt. The comparative anatomists have shown us how frequently it is present outside of the human race, such as in cattle, rabbits and mice. There is also some reason to believe that it was probably present in the dinosaur. This pushes us back to the Third Inter-Glacial Period.

Much literature has been written on the subject by the ancient writers; and one of the best examples is found in the New Testament, Luke 13:11, which goes as follows:

> "And behold, there was a woman which had a spirit of infirmity eighteen years, and was bowed together, and could in no wise lift up herself."

Even though the disease is so old, its cause escapes us and treatment is still very inadequate. The following list of books will give you the story of Arthritis from earliest days up to the present time and are available in our Library:


Allison, N. and Ghormley, R. K. Diagnosis in joint disease; a clinical and pathological study of arthritis. N. Y., Wood, 1931.

Beck, B. F. Bee venom therapy . . . N. Y., Lond., D. Appleton-Century, 1935.

British national committee on chronic rheumatic diseases. Annual report, no. 3. Lond., H. K. Lewis & Co. ltd., 1937.

Buckley, C. W. Arthritis, fibrositis and gout. Lond., H. K. Lewis & Co. ltd., 1938.

Burckhardt, H. Arthritis deformans und chronische gelenkkrankheiten. Neue deutsche chirurgie v. 52. Stutt., F. Enke, 1932.

Cecil, R. La F. The diagnosis and treatment of arthritis. Oxf. Mono. on diag. and treatment v. 6. N. Y., Oxf. univ. pr. (c1929).

Coates, V. and Delicati, L. Rheumatoid arthritis and its treatment. Lond., H. K. Lewis & Co., ltd., 1931.

Comroe, B. I. Arthritis and allied conditions, 3rd ed. Phila., Lea & Febiger, 1944; also 4th ed., 1949.

Crowe, H. W. Bacteriology & surgery of chronic arthritis and rheumatism, with end-results of treatment. Lond., N. Y., Humphrey Milford, Oxf. univ. pr., 1927.

Crowe, H. W. The treatment of chronic arthritis and rheumatism. Lond., N. Y. (etc.) Humphrey Milford, Oxf. univ. pr., 1926.

Daniel, P. Arthritis, a study of the inflammatory diseases of joints, ed. by J. Cantlie. N. Y., Wm. Wood & Co., 1911.

Freund, E. Gelenkerkrankungen; einfuhrung in die Pathologie und Therapie. Berl., Urban & Schwarzenberg, 1929.

Hoffa, A. J. and Wollenberg, G. A. Arthritis deformans und sogenannter chronischer gelenkrheumatismus. Stutt., F. Enke, 1908.

Holbrock, W. P. and Hill, D. F. Manual of rheumatic diseases. Chic., Year Book Pub., 1950.

Jones, R. L. Arthritis deformans: comprising rheumatoid arthritis, osteoarthritis, and spondylitis deformans. N. Y., Wood, 1909.

Kling, D. H. The synovial membrane and the synovial fluid with special ref. to arthritis and injuries of the joints . . . Los Angeles, Med. Pr., 1938.

Knaggs, R. L. The inflammatory and toxic diseases of bone. Brist., John Wright & Sons, ltd., Lond., Simpkin, Marshall, Hamilton, Kent & Co., ltd., 1926.

Lautman, M. F. Arthritis and rheumatic disease. N. Y., Whittlesey, 1936.

Llewellyn, R. L. J. Aspects of rheumatism and gout. Lond., Heinemann, 1927.

Llewellyn, R. L. J. and Jones, B. Fibrositis (gouty, infective, traumatic). N. Y., Reban Co., 1917.


* Chairman, Library Committee.

Llewellyn, R. L. J. Gout. Lond., Heinemann, 1920.
Loomis, A. L. and Thompson, W. G. System of practical medicine, v. 4. N. Y., Phila., Lea Brothers & Co., 1898.
Margolis, H. M. Conquering arthritis. N. Y., Macmillan, 1931.
Nicoll, S. Dissertatio medica inauguralis de arthritide. Edin., Balfour et Smellie, 1776.
Pemberton, R. Arthritis and rheumatoid conditions; their nature and treatment. Phila., Lea, 1929; also 2d ed., 1935.
Pemberton, R. and Osgood, R. B. The medical and orthopaedic management of chronic arthritis. N. Y., Macmillan, 1934.
Pribham, A. Chronischer Gelenkrheumatismus und Osteoarthritis Deformans, (In Nothnagel. Specielle Pathologie und Therapie, v. 7, pt. 2. Wien, Alfred Hölder, 1902.)
Steinbrocker, O. Arthritis in modern practice. Phila., Saunders, 1941.
Stockman, R. Rheumatism and arthritis. Edin., W. Green & Son, ltd., 1920.
Talbott, J. H. Gout and gouty arthritis. N. Y., Grune & Stratton, 1953.
Thomson, F. G. and Gordon, R. G. Chronic rheumatic diseases, their diagnosis and treatment. Lond., Milford, 1926.
Wilde, P. The physiology of gout, rheumatism, and arthritis, as a guide to accurate diagnosis and efficient treatment. N. Y., Wood, 1922.
Wyatt, B. L. Chronic arthritis and fibrositis; diagnosis and treatment. Balto., W. Wood & Co., 1933.
Wyatt, B. L. Chronic arthritis and rheumatoid affections, with recovery record. N. Y., W. Wood, 1930.

## A SELECTED LIST OF PUBLICATIONS RECENTLY ADDED TO THE LIBRARY

* Barta, F. R. Moral theory of behaviour. Springfield, Thomas, 1952.
* Benda, C. E. Mongolism and cretinism. 2d ed. New York, Grune and Stratton, 1949.
Biggs, R. and Macfarlane, R. G. Human blood coagulation. Oxford, Blackwell, 1953.
* Binger, C. A. L. Personality in arterial hypertension. New York, American Society for Research in Psychosomatic Problems, 1945.
* Bond, E. D. Dr. Kirkbride and his mental hospital. Philadelphia, Lippincott, 1947.
* Bond, E. D. Thomas W. Salmon, psychiatrist. New York, Norton, 1950.
* Brill, A. A. Lectures on psychoanalytic psychiatry. New York, Knopf, 1946.
Browne, D. G. and Tullett, E. V. The scalpel of Scotland Yard. New York, Dutton, 1952.
* Clark, M. Medicine on the march. New York, Funk & Wagnalls, 1949.
Dameshek, W. and Welch, C. S. Hypersplenism and surgery of the spleen. New York, Grune & Stratton, 1953.
* Deri, S. Introduction to the Szondi test. New York, Grune & Stratton, 1949.
* Evans, B. The psychiatry of Robert Burton. New York, Columbia University Press, 1944.
* Fischer, S. Principles of general psychopathology. New York, Philosophical Library, 1950.
Fulton, J. F. Frontal lobotomy and affective behaviour. New York, Norton, 1951.
Graybiel, A. Electrocardiography in practice. 3d ed. Philadelphia, Saunders, 1952.
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* Harvard University School of Public Health—Proceedings of the symposium in industrial medicine. Boston, Harvard University Press, 1953.
Index generalis. Paris, Dunod, 1953.
* Kendall, H. O. Muscles, testing and function. Baltimore, Williams & Wilkins Co., 1949.
Kinsey, A. C. Sexual behaviour in the human female. Philadelphia, Saunders, 1953.
* London, L. S. Sexual deviations. Washington, Linacre Press, 1950.
MacBryde, C. M. Signs and symptoms. 2d ed. Philadelphia, Lippincott, 1952.
Miller, S. E. Textbook of clinical pathology. 4th ed. Baltimore, Williams & Wilkins, 1952.
* Napier, L. Principles and practice of tropical medicine. New York, Macmillan, 1946.
* Nicola, T. Atlas of surgical approaches to bones and joints. New York, Macmillan, 1945.

* Indicates gifts.

* Nixon, P. I. History of the Texas Medical Association. Austin, Texas, University of Texas, 1953.

* Orley, A. Neuroradiology. Springfield, Thomas, 1949.

Palmer, E. D. Esophagus and its diseases. New York, Hoeber, 1952.

* Psychiatry and the war. Springfield, Thomas, 1943.

* Rapaport, D. Diagnostic psychological testing. Chicago, Yearbook Publ., 1945–46. 2 vols.

* Rees, J. R. The shaping of psychiatry by war. New York, Norton, 1945.

* Rosenzweig, S. Psychodiagnosis. New York, Grune & Stratton, 1949.

* Rusk, H. A. Living with a disability. New York, Blakiston, 1953.

Scientific and learned societies of Great Britain. London, Allen & Unwin, 1952.

Shock and circulatory homeostasis. New York, Josiah Macy, Jr. Foundation, 1953.

Starr, I. Physiologic therapy for obstructive vascular disease. New York, Grune & Stratton, 1953.

* Stein, M. I. The thematic apperception test. Cambridge, Addison-Wesley, 1948.

* Stitt, E. R. Practical bacteriology. 10th ed. Philadelphia, Blakiston, 1948.

* Tompkins, S. S. Contemporary psychopathology. Cambridge, Harvard University Press, 1943.

* Walshe, F. M. R. Diseases of the nervous system. 5th ed. Baltimore, Williams & Wilkins, 1947.

The world of learning. London, Europa pub., 1953.

Yearbook of medicine. Chicago, Yearbook, 1953.

## JUSTICE DEPARTMENT TO HANDLE NON-SERVICE CONNECTED INVESTIGATIONS

The AMA Washington Letter, No. 41

Under a new plan about to be put into effect by Veterans Administration, the *Department of Justice* will be called in to handle cases of suspected fraud concerning the "inability to pay" declaration of veterans with non-service connected disabilities. VA itself is forbidden by law to look behind the veteran's statement that he can't afford private treatment. According to testimony introduced in Congressional hearings, this has resulted in many abuses.

The new arrangement provides that if a VA hospital manager has good grounds to suspect that the veteran's claim of indigency is fraudulent, he will confer with federal law-enforcement officials. An investigation will then be conducted by Justice Department, the regular law-enforcement arm of the federal government. If the facts justify prosecution, the case will be taken to federal court. There the government will have to prove that the veteran in question set out "premeditatedly, purposefully and intentionally" to defraud the government.

Also nearing the announcement stage is a tightening up of the questionnaire filled out by veterans with non-service connected conditions when they apply for VA hospitalization. VA medical and legal officials have been working on the new wording since last spring.

It is expected the revised form will call on the veteran to supply more information about his finances. The new questions are being given a final check by VA attorneys before presentation to the Administrator.

# Health Departments

## LEGAL PROCEDURES IN TUBERCULOSIS CONTROL

EDWIN G. RILEY, M.D.*

*Denton, Md.*

In Maryland legal means are resorted to by State and County Health Departments only when the health of an individual is a serious threat to others and all attempts by the educational route have failed.

The recent panel discussion on tuberculosis reported in the Maryland State Medical Journal mentioned the use of legal procedures to force treatment for this disease.[1] An article in the United States Public Health Reports states this to be the only method of handling the recalcitrant tuberculosis patient.[2]

In Caroline County among the sixty-four known cases of tuberculosis four have presented difficult problems of accepting care. After every other method had failed it was felt that legal steps were the last resort.

P.R.—White, male, twenty-eight years old, living with his wife, one six-year old daughter, his brother, his brother's wife and two small children.

In 1948 he was diagnosed by the Health Department as having moderately advanced active tuberculosis with a positive sputum. He refused to accept this diagnosis until it was confirmed by his own physician. At this time the children were tuberculin negative. He entered the sanatorium, gained weight, and improved in general. After being in the hospital five months, he absented himself. The patient was seen in the Health Department Clinic and at home during the next four months. Finally he stopped attending the clinic saying that he was unable to obtain the money to travel the twenty miles from his home. It was then suggested that he return to the hospital to have treatment for pleural adhesions. He refused.

The patient and his family were given aid by the Welfare Department although it was suggested that if he did not obtain treatment this assistance might be discontinued. He replied he would go to work. Aid was continued.

Finally a neighbor complained that the man was exposing others in the neighborhood. It was now learned that he was being treated by his local physician although his course was progressively worse. He began avoiding representatives of the Health Department. A second neighbor called the Health Department because she was concerned that her children were being exposed to the patient. The man's physician was consulted. He too had urged the man to be hospitalized without success.

The health officer warned P.R. that it was the opinion of his own physician as well as the health authorities that he should return to a sanatorium or legal steps would be taken to see that he was isolated. After the man expressed repeated belligerence a trial was arranged. He was found guilty as charged and sentenced to nine months with a suspended sentence if he would immediately enter a sanatorium. This he agreed to do.

He was admitted to a state sanatorium within several days. Four days later he left. The health officer again visited the man in his home and was told that the patient would not return to the sanatorium. A second warrant was issued and the man brought into court. At this time the magistrate told him he must be in a hospital within twenty-four hours. The next day it was learned that the patient had seen a local lawyer who had arranged for the patient to be admitted to a clinic in Philadelphia which treats all stages of tuberculosis on an out-patient basis. It was agreed that he could go to Philadelphia as long as he did not live in Maryland while taking treatment. He entered the clinic as an in-patient. His family informed the Health Department that he was quite satisfied at the clinic and at the end of four months was said to be sputum negative and returned home.

A letter has been received from the Philadelphia

* Health Officer, Caroline County.

[1] "Symposium on the Tuberculosis Problem in Baltimore," Maryland State Medical Journal **2:** 2, 1953.

[2] "Practical Management of the Recalcitrant Tuberculosis Patient," Northrop, Fountain, and Zahn, United States Public Health Reports—Vol. **67:** 9, September 1952.

Clinic indicating P.R. had not kept out-patient appointments there. Further steps will be needed before this case can be closed.

Here is another: D.J.—white, male, fifty-seven years old, living with his wife and two small grandchildren, first became known to the Health Department through the Veterans Administration in 1934 for a moderately advanced active case of tuberculosis. Although the Health Department has worked with the man and his family since that time, it was not until 1950 that he was persuaded to re-enter a veterans' hospital for treatment, leaving shortly after. In 1952 after discussion with the local physician (who had not seen the man in several years and who agreed that something should be done) the health officer visited the man and learned that he would go back to a veterans' hospital but would like to go to one near home. The Veterans Administration Hospital was contacted, and it was learned that it would be six months before he could be admitted. Patch tests on the grandchildren at this time were negative. This man was an alcoholic who placed the burden of supporting the family on his wife. In June 1952 he was admitted to a state hospital from which he was discharged for disciplinary reasons.

About a week later he was brought into court where he agreed to go to a hospital. Authorities agreed to readmit him to an institution on the Western Shore. On the way to the hospital he stopped in Baltimore, became drunk and was sent home in a taxi by the Baltimore police with a $40 taxi bill for his wife.

He was again brought into court, sentenced to nine months in prison and placed in Jessups in a cell with another prisoner. In about two weeks he was transferred to the Maryland State Reformatory for Males which has a ward for tuberculosis patients. This ward is visited monthly by the Medical Director of the Maryland Tuberculosis Hospitals of the State Department of Health and appears to offer excellent care. In anticipation of D.J.'s return home the Section on Alcohol Studies of the State Health Department has been of great assistance in outlining an approach to this man's serious problem of alcoholism. It was planned to enlist the aid of the local constable, priest, and physician. The man refuses to recognize the fact that he is a problem drinker. He has evidenced no desire or intention of overcoming his defect.

Shortly before his discharge from prison it was learned that he wished to enter a veterans' hospital. A bed was available for him before his term was up. Since he could not be released except by the Governor commuting his sentence, an extension of the time of his admittance to the Veterans' Hospital was granted on the understanding that he would stay at least six months. It was learned he had "some important business" at home before he entered any hospital. A representative of the alcoholic studies group planned to meet him as he left prison to persuade him to go directly to the Veterans' Hospital. His family was not agreeable to this idea and expressed some resentment of "sending him to jail just because he had tuberculosis." He is now at home.

The third case is that of A.L.—white, male, thirty-seven years old, living with his wife and four small children. He came to the attention of the Health Department in 1948 with moderately advanced active tuberculosis. From the first he was reluctant to follow medical recommendations. He entered a hospital after the local Tuberculosis Association gave him $312 to pay some debts which he claimed prevented him from leaving home. He left the sanatorium against advice in a month because he had "nothing to do" while there. Numerous home visits were made by Health Department nurses both to arrange for his treatment with streptomycin while at home and to educate the family as to the seriousness of the situation and the desirability of his returning for care. Although cooperating with the Health Department in other respects, his wife has consistently refused to have an X-ray and never has had one.

Various things made the progress of his treatment unsatisfactory. On clinic days the "car broke down" or the children needed something and many other reasons were offered why he could not present himself. Assistance was arranged for the family and man through the Welfare Department. The condition at the end of 1948 was acute and the patient was very ill (with vomiting and severe malaise). He persisted in getting out of bed and "looking after the household." Early in 1949 he again entered the sanatorium. In two months he was feeling better and had gained weight. He absented himself against

advice because no one had told him "how he was getting along." After being out two months, after many visits by the nurses, the man re-entered the sanatorium. He left within one month against advice because his wife was going to have another baby.

Debt and family responsibilities hung heavily on him. At best his condition would allow him only sporadic work. In 1951 he again entered the sanatorium. He left in three months on his own accord after he had been moved from a private room. During his stay he gained twenty-two pounds and was much improved. The children now all had positive patch tests. Steps were started to bring the family into juvenile court because of the exposure of the children. This was not carried through when the man promised to leave the home. This he did not do. In 1952, the patient developed laryngitis and was still working on and off while under the care of a local physician, receiving streptomycin and PAS. His own physician felt that A.L. should be in a hospital even by legal means if necessary.

The man was brought into court. He was represented by legal counsel who said that he was not getting a fee for the case, but was representing the man as a favor to some persons in the patient's town who wished to see that the man got a "fair shake." The patient did not seem to accept the fact that he was suffering from a dangerous infectious disease or that he was endangering the health of others by his present course of action. He was found guilty. Sentence was suspended if he would enter a hospital within two weeks. The lawyer arranged for him to enter the same clinic in Philadelphia in which R.P. was treated and also as an in-patient. At the time of this report the man is still in Philadelphia.

The last case concerns G.P.—male, white, fifty-one years old, living with his wife and 12 year old daughter. The man was first seen in the Health Department clinic in 1950. At this time he was under the care of the Philadelphia clinic mentioned earlier as an out-patient going periodically for treatment. His diagnosis was advanced, active bilateral tuberculosis with a consistently positive sputum. His tuberculosis was discovered while in a hospital in Delaware for a rectal fistula. There he was advised to go to a tuberculosis hospital. Instead he went to the clinic in Philadelphia where he could "go for a few days and return home." His wife and daughter have cooperated with the Health Department but the man has not followed the instructions of the Philadelphia clinic. He has continued to work and denied that the clinic had told him to limit his activities. He has also claimed that he had to provide for his family although his wife has been the real support since the onset of his illness.

A visit was made by the county health officer to the clinic in Philadelphia to discuss D.J., A.L., and G.P. It was pointed out that these men could not be allowed to violate Maryland law in spite of the fact that they were under medical supervision. The clinic management was forewarned that patients would be prosecuted when they were in violation.

The health officer also visited G.P. and explained the situation. He was told that it was not possible for him to continue exposing his daughter to his infection. He denied having contact with other people but it was learned that his five year old grandson also visited in the home. The patient refused to go to the hospital and since he lives about a quarter of a mile from Delaware, he asked if he could not be told when he was going to be arrested so that he might go over the state line. He was told he was free to move out of the state, but this could not be advised.

The man was brought into court, found guilty and the case continued to give the man an opportunity to enter a hospital.

A meeting was later held with the Chief of the Bureau of Tuberculosis of the Maryland State Health Department in an effort to develop better understanding of the operation of the sanatoriums and what they are doing.

The court was again asked to bring the man before it. The constable who was requested to get the man refused to do so stating "if the man is as dangerous as all that I'm not going to carry him in my car and expose myself to the disease. I have carried my last tuberculosis case."

The man was finally brought before the court and was directed to appear at the County Health Department to determine if he was infectious. A gastric washing was done and found to be microscopically positive. The man asked to be admitted to the Philadelphia clinic as an in-patient but he lacked funds. The local citizen who is a member of the clinic board

was sent a letter asking if he could assist the man in this matter but no reply was received.

The magistrate was again asked to bring the man into court. G.P.'s wife then called stating the man was waiting for a bed at the Philadelphia clinic. The court on being informed of this asked to be kept further advised of his progress.

DISCUSSION

*Legal aspects*—The Maryland law states "any person who, while suffering from any dangerous infectious disorder, willfully exposes himself . . . without proper precautions . . . in any street (or) public place . . . shall be liable to a penalty not exceeding five hundred dollars or imprisonment not exceeding twelve months, or both, in the discretion of the circuit court for the county . . ."*

In order to be liable the individual must appear in a public place. If the four cases had stayed in their homes (no matter how many people were living with them or visiting them) there would be no basis for prosecution.

In order to establish the charge, the violator must be seen in public by a witness who will appear in court and swear that he was seen at the time which is required to be specified in the warrant.

In the first case, the neighbors were asked to be witnesses and although several of them had complained about the patient, none of them wanted to appear in court. Two women finally agreed to testify. Also at the time of the first trial it was not known that these witnesses had seen the man in a public place on the day charged. It developed that they had. In subsequent cases either a nurse or health officer arranged to see the individual in public before the warrant was issued.

In the first hearings the magistrate imposed sentence which was suspended pending suggested action on part of the patient. By so doing the case was closed. If the patient does not do as directed he must be charged in a new complaint.

*Public reaction*—Some of the most well-informed citizens of the community obviously do not comprehend the nature and seriousness of tuberculosis. The concept that an individual may be seriously ill and a threat to other people although he does not have pain or any marked signs of illness is evidently a difficult one for people to fully understand.

* Md. Annotated Code, 1951, Art. 43, Sec. 57.

*Evaluation*—A great deal of time has been required to follow these four cases through the court. The final result with any one of them is not yet known. Further recourse to the court may be required.

At present, one case is hospitalized. Another case is in the process of being admitted. The other two are improved and at home. Of the latter, one may be more cooperative in the future and one will continue a problem until his drinking is checked. He is at this time no longer sputum positive.

The health officer has no choice except to protect the community and must follow these cases closely until they are no longer infectious.

R. H. Riley

*Director*

## BALTIMORE CITY HEALTH DEPARTMENT

### The Medical Care of Foster Children

Foster children, while they are wards of the Baltimore City Department of Public Welfare and living within the limits of the City of Baltimore, will receive health services and medical care through the Baltimore City Medical Care Program. The Program gives these children the following services when needed:

1. Physician services in his office
2. Physician services in the home of the foster parent
3. Complete medical examination
4. Consultation services of specialists
5. Treatment by specialists
6. Medicines and some medical supplies
7. Dental treatment
8. Eyeglasses.

*Physician Services*

Soon after a child has been accepted by a foster parent under the City Department of Public Welfare the parent will be asked by the Medical Care Clinic of the Baltimore City Hospitals to choose a physician for the child. The child then may be in

good health. Usually the physician chosen by the foster parent will be the one who cares for other children living in the home.

The physician selected and agreeing to accept responsibility for the child's care under the Baltimore City Medical Care Program will provide required medical services at his office and, when necessary, in the home of the foster parent. The physician should not be asked to visit the home unless the child is too ill to be taken to his office. The foster parent should be on the lookout for early symptoms of disease and the child should be taken to see the doctor without delay when his services are required but in order to properly conserve the doctor's time he should not receive calls from those who do not need his attention.

*Drugs*

If a child under the Baltimore City Medical Care Program needs medicine it can be obtained through a prescription written by the child's physician and filled at a drug store, usually nearby, selected by the foster parent. Some medical supplies, also, are available in this way.

*Specialist and Hospital Services*

If the physician chosen for the child requires advice or other assistance from a physician who has had special training and experience in the disease from which the child is suffering or if the services of a laboratory are required this assistance is available quickly and easily on the physician's request.

If the child's illness requires continued care in a hospital arrangements for admittance to the hospital should be made by a request from the attending physician directly to the admitting officer of the Baltimore City Hospitals. However, the Medical Care Clinic of that hospital will give assistance if its help is required to secure a hospital bed necessary for a foster child.

*Identification Card*

Soon after the child's physician has been selected, the foster parent will receive an identification card by mail from the Medical Care Clinic of the Baltimore City Hospitals. This card will bear the name of the child and the physician's name, address and telephone number. This card is valuable and should be kept safely. It should be presented to the physician whenever his services are required, to the druggist whenever a prescription for the child is filled and to the hospital when the child makes a visit there.

Regularly at the first of every quarter year (January 1, March 1, July 1 and October 1) the Medical Care Section of the Baltimore City Health Department will mail the child a new identification card as long as he remains eligible for services under the Baltimore City Medical Care Program. If an identification card is lost the foster parent promptly should telephone the Medical Care Clinic, Baltimore City Hospitals, requesting a replacement card.

Next to the physician chosen for the child the responsibility for his medical care rests with the Medical Care Clinic of the Baltimore City Hospitals. This clinic stands ready to provide any information which the foster parent may need regarding the Baltimore City Medical Care Program.

The telephone number of the Medical Care Clinic of the Baltimore City Hospitals is DIckens 2-5400, Extension 467.

Huntington Williams, M.D.

*Commissioner of Health*

## STATE OF MARYLAND DEPARTMENT OF HEALTH
## MONTHLY COMMUNICABLE DISEASE REPORT

*Case Reports Received during 4-week Period, October 30–November 26, 1953*

| | CHICKENPOX | DIPHTHERIA | GERMAN MEASLES | HEPATITIS, INFECT. | MEASLES | MENINGITIS, MENINGOCOCCUS | MUMPS | POLIOMYELITIS, PARALYTIC | POLIOMYELITIS, NON PARALYTIC | ROCKY MT. SPOTTED FEVER | STREP. SORE THROAT INCL. SCARLET FEVER | TYPHOID FEVER | UNDULANT FEVER | WHOOPING COUGH | TUBERCULOSIS, RESPIRATORY | SYPHILIS, PRIMARY AND SECONDARY | GONORRHEA | OTHER DISEASES | DEATHS: Influenza and pneumonia |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Total, 4 weeks** | | | | | | | | | | | | | | | | | | | |
| Local areas | | | | | | | | | | | | | | | | | | | |
| Baltimore County | 33 | — | 2 | 5 | 10 | 1 | 28 | 5 | 7 | — | 4 | — | — | 1 | 4 | 1 | 3 | r-2 | — |
| Anne Arundel | 3 | — | — | — | — | — | 3 | 1 | — | — | 1 | — | — | 1 | 7 | — | 7 | — | 1 |
| Howard | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | 3 | — | — |
| Harford | — | — | 1 | 2 | 1 | — | 22 | 1 | — | — | 3 | — | — | 4 | 3 | — | 1 | — | — |
| Carroll | — | — | — | 1 | — | — | 1 | — | — | — | 1 | — | — | — | — | — | 1 | — | 1 |
| Frederick | — | — | — | — | — | — | — | 2 | — | — | — | — | — | — | 3 | — | 2 | — | — |
| Washington | 2 | — | — | — | — | 1 | 1 | 1 | — | — | 2 | — | 1 | — | 5 | — | 2 | — | — |
| Allegany | — | — | — | — | — | — | — | — | — | — | — | — | — | — | 2 | — | — | — | — |
| Garrett | — | — | — | — | — | — | 1 | — | 1 | — | — | — | — | — | — | — | — | — | — |
| Montgomery | 5 | — | — | — | 1 | 1 | 15 | 1 | — | 1 | 5 | — | — | — | 4 | — | 2 | — | 1 |
| Prince George's | 10 | — | 1 | 1 | 1 | — | 4 | — | 1 | — | — | — | — | 2 | 7 | — | 3 | — | 2 |
| Calvert | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | 1 |
| Charles | 1 | — | — | — | — | — | — | — | — | — | 1 | — | — | — | 2 | — | 1 | — | — |
| Saint Mary's | 2 | — | — | — | — | — | — | — | — | — | — | — | 1 | — | 2 | — | 1 | — | — |
| Cecil | — | — | — | — | — | 1 | — | 1 | — | — | — | — | — | — | 2 | — | 2 | — | — |
| Kent | — | — | — | 3 | 1 | — | — | — | — | — | — | — | — | — | — | — | — | — | 1 |
| Queen Anne's | — | — | — | — | — | 1 | — | — | — | — | 1 | — | — | 7 | 1 | — | 1 | — | — |
| Caroline | 1 | — | — | — | — | — | 1 | — | — | — | 3 | — | — | — | 1 | — | 2 | — | — |
| Talbot | 2 | — | — | — | — | — | — | — | — | — | — | — | — | — | — | — | 1 | — | — |
| Dorchester | — | — | — | — | — | — | — | — | — | — | — | — | — | — | 1 | — | 16 | — | — |
| Wicomico | — | — | — | — | 43 | — | — | — | — | — | — | — | — | — | 5 | — | 7 | — | 1 |
| Worcester | — | — | — | — | 3 | — | 2 | — | — | — | — | — | — | — | 1 | — | 1 | — | — |
| Somerset | — | — | — | — | — | — | — | — | — | — | — | — | — | — | 2 | — | — | — | — |
| Total Counties | 59 | 0 | 4 | 12 | 60 | 5 | 78 | 12 | 9 | 1 | 21 | 0 | 2 | 15 | 52 | 1 | 56 | | 8 |
| Baltimore City | 90 | 0 | 7 | 6 | 94 | 2 | 87 | 1 | 4 | 0 | 22 | 2 | 0 | 24 | 84 | 10 | 437 | | 23 |
| State | | | | | | | | | | | | | | | | | | | |
| Oct. 30–Nov. 26, 1953 | 149 | 0 | 11 | 18 | 154 | 7 | 165 | 13 | 13 | 1 | 43 | 2 | 2 | 39 | 136 | 11 | 493 | | 31 |
| Same period 1952 | 158 | 5 | 9 | 24 | 39 | 3 | 68 | 31 | 27 | 0 | 68 | 1 | 1 | 22 | 179 | 12 | 635 | | 37 |
| 5-year median | 118 | 5 | 5 | — | 37 | 2 | 41 | 21 | | 0 | 59 | 4 | 2 | 58 | 185 | 60 | 600 | | 39 |
| **Cumulative totals** | | | | | | | | | | | | | | | | | | | |
| State | | | | | | | | | | | | | | | | | | | |
| Year 1953 to date | 2899 | 11 | 1450 | 447 | 1708 | 73 | 2489 | 301 | 215 | 25 | 2267 | 31 | 12 | 375 | 2093 | 143 | 7172 | | 636 |
| Same period 1952 | 2917 | 13 | 849 | 222 | 9127 | 79 | 998 | 194 | 160 | 28 | 948 | 20 | 15 | 194 | 2426 | 176 | 6845 | | 579 |
| 5-year median | 3195 | 68 | 535 | — | 4050 | 63 | 1654 | 217 | | 56 | 982 | 34 | 38 | 742 | 2488 | 784 | 6947 | | 551 |

r = positive rabies reports in animals.

# Blue Cross - Blue Shield

## FINANCIAL STATEMENTS OF MARYLAND MEDICAL SERVICE, INC.

### Balance Sheet

(As of September 30, 1953)

*Assets*

| | |
|---|---|
| Cash on deposit | $309,035.98 |
| Subscriptions & Accounts Receivable | 199,526.05 |
| Total Assets | $508,562.03 |

*Liabilities and Reserves*

| | |
|---|---|
| Accounts Payable | $177,244.15 |
| Reserves for Unreported and Pending Care | 157,000.00 |
| Unearned Subscription Charges | 87,698.79 |
| Reserve for Contingencies | 86,619.09 |
| Total Liabilities and Reserves | $508,562.03 |

*Operating Statement*

(9 months ended September 30, 1953)

| | | |
|---|---|---|
| Subscription Income | $1,243,535.64 | 100.0% |
| Medical Care for Subscribers | $1,054,259.92 | 84.8% |
| Balance after Medical Care | $ 189,275.72 | 15.2% |
| Administrative Expenses | $ 138,479.77 | 11.1% |
| Balance for Reserves | $ 50,795.95 | 4.1% |

### Comments

While operations to date have resulted in an excess of income over expenditures, the funds that the Plan has thus far been able to set aside for reserves have not been wholly adequate in relation to established standards.

Reserves as of September 30 were sufficient for 1.31 months of average monthly expenditures (medical and administrative expense) as compared with 2.98 months average for 21 Blue Shield Plans in our size classification. However, experience has been improving and is expected to continue to improve as the Plan grows in size. There has been an increase of over 20,000 in membership since January 1, 1953.

R. H. Dabney, *Director*

# Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. CHARLES H. WILLIAMS, *Auxiliary Editor*

## MEMBERSHIP

MRS. MARTIN E. STROBEL

In order to institute and maintain a flourishing State Auxiliary, it is important to increase membership. It is hoped that this can be accomplished in three ways:

1. By organizing county medical auxiliaries where county societies exist.
2. By increasing and strengthening membership in existing auxiliaries.
3. By enrolling members-at-large.

It must be remembered that unorganized counties can be organized only with the consent of their County Medical Societies. These counties should study their special problems and enlist the help of the State Auxiliary in planning for the organizational meeting of the new counties. A sample Constitution and By-Laws of County Medical Auxiliaries can be obtained for use in organizing.

County auxiliaries that have already organized should invite eligible members in neighboring unorganized groups to their meetings as guests. It is important, however, to check the Medical Society roster for names *always*. Organized groups can also obtain the names of members-at-large in the State Auxiliary and invite them as guests to their meetings. One person can do much to effect organization in an unorganized county.

Membership in existing auxiliaries can be increased and strengthened in many ways, such as the following:

1. Check monthly with the Secretary of the Medical Society for names of the physicians who have become new members.
2. Give new members responsibility.
3. Hold meetings as regularly as possible.
4. Keep programs activated with many participating.
5. Work constructively and diligently to maintain membership interest.
6. Hold occasional joint meetings with the Medical Society and have fun together.

Each member of a county auxiliary must realize that it is our combined efforts that will assure others that we are qualified leaders in health. In order to be a good member, observe the following rules:

1. Attend auxiliary meetings regularly.
2. Participate in auxiliary activities—say "yes" when asked to serve. Remember you had a predecessor. Seek her cooperation and use her material.
3. Ask yourself as a member "What can I contribute?"
4. Learn to know others: be friendly and seek new friendships.
5. Enroll a new member.
6. Appreciate your privilege—others would enjoy what you regard as unimportant.
7. Activate people in your community to an appreciation of American medicine and our system of free enterprise. Contact your neighbors, club friends, business associates, and church members.

Above all, remember that a small Auxiliary is important. An Auxiliary member in a small group is almost an Auxiliary in her own right.

## AUXILIARY PUBLIC SERVICE THE GATEWAY TO GOOD PUBLIC RELATIONS*

### Fundamentals of a Good Public Service Program

*First Step—Informed Membership*

It is a fundamental truism that in order to solve a problem we must not only recognize and know the problem but we must learn the various steps and kind of action necessary for its solution. In order to act as an interpreter for the medical profession we must necessarily know the problems confronting

* Reprinted from A.M.A. Woman's Auxiliary Public Relations Pamphlet, "The Medical Auxiliary and Public Service."

the profession and the solutions offered by the profession. Therefore, complete and thorough self education is the first essential in facing and solving our problems.

*Second Step—Contacts*

Every doctor's wife has contacts with other organizations which can and should provide valuable avenues for furthering good public relations. Auxiliary members as individuals participate in educational, civic and religious groups and in numerous health organizations. Auxiliary members have many daily contacts with community leaders. In the "extremely valuable" category are the contacts with public officials, educational personnel, leaders of civic, religious, patriotic, labor and farm organizations, and philanthropic and character building agencies. All of these relationships must be enlarged and extended. Through them our efforts can be multiplied a hundredfold, while without them progress will be almost imperceptible.

*Third Step—Service*

In order to develop good public relations every auxiliary must be a public service organization. Only through this media can we hope to achieve our ultimate goal. Paramount of course, must always be the question, "What can we do that will be of most service to our community in the field of health?"

Auxiliaries could and should utilize the work and enthusiasm of every doctor's wife in every organization and community project, in which she as an individual participates, and thus make the work and accomplishments of every doctor's wife, in every field of endeavor pay dividends to the professional family, to the auxiliary and mankind. Public relations has been defined as doing good. It will bring its own reward to us and the great humanitarian profession of medicine. Every auxiliary by careful inventory and planning could serve through its membership as a clearing house for community service. A check or report of the activities of individual members would provide enlightenment concerning many community projects and could furnish valuable resources and support for those activities and projects needing and deserving additional attention. In this manner auxiliaries could very shortly develop a reputation as a service organization, where other community service organizations could always find assistance for needed community projects and action. In this way the Medical Association's family would gain the complete confidence of the community and assume leadership and recognition for activities in the field of health and health education. Only by a sincere interest and participation in all civic problems affecting the community can we expect to assume our proper role in the field of health and leadership. By doing what any good citizen or neighbor could and should do we will meet our inherited and acquired responsibility "For A Better World;" by working together and thus be rightfully proud of the privilege of membership in the Woman's Auxiliary to the American Medical Association.

PUBLIC SERVICE IS EVERYBODY'S BUSINESS AND "THE OBLIGATION IS OURS"

## A.M.A. MAKES AVAILABLE FOUR TELEVISION SHOWS

People who attended the A.M.A. Public Relations Institute in Chicago last week were quite enthusiastic over the four new television shows which are being made available by the A.M.A. to state and county medical societies.

These films, earmarked for use by local medical societies only, were designed for airing on "public service time" over local TV stations. They will not be shown on any national TV network.

Each program deals with a different popular medical subject:

(1) "Operation Herbert"—a fast-moving, humorous play discussing medical care costs—stars well-known actor Jackie Kelk; (2) "A Citizen Participates"—documentary-type story tells about a town that needs a doctor and how one citizen heads a campaign to get one: (3) "What to Do"—series of six five-minute shows with ABC women's commentator Nancy Craig demonstrating how to use a thermometer, apply artificial respiration, stock a medi-

cine chest, and treat colds, abdominal pains and headaches, and (4) "Your Doctor"—Louis de Rochemont's film, now available for the first time on TV—describes medical training facilities today.

Prints of these new filmed TV shows may be obtained from the A.M.A.'s TV Film Library, 535 North Dearborn Street, Chicago 10, Ill. These shows must be booked well in advance of schedule date.

SUMMARY—MEMBERSHIP-ORGANIZATION-BULLETIN-TODAY'S HEALTH*

| State | Component societies | County auxiliaries | Membership Med. & Chi. Faculty | A.M.A. membership | Auxiliary membership | Bulletin subscriptions | Today's health credits |
|---|---|---|---|---|---|---|---|
| Maryland | 23 | 6 | 2,441 | 1,597 | 426 | 104 | 92 |

* A.M.A. Woman's Auxiliary Bulletin, Vol. 15, August, 1953.

## *Appreciation to the Woman's Auxiliary of the Baltimore City Medical Society Regarding the AMEF*

**Medical and Chirurgical Faculty of the State of Maryland**

1211 CATHEDRAL STREET, BALTIMORE 1, MARYLAND

October 27, 1953

Mrs. Margaret Webster
President of the Woman's Auxiliary to the
Baltimore Medical Society
4336 North Charles Street
Baltimore 18, Maryland

Dear Mrs. Webster:

The American Medical Education Foundation of which I am State Chairman is most pleased to be the recipient of a very generous contribution from your fine organization.

We have received a check in the amount of five hundred dollars ($500.00) which will be forwarded immediately to our headquarters in Chicago. This contribution was only made possible through the almost heroic efforts of your Auxiliary in presenting the Faculty Ball at the Alcazar last spring, and by the cooperation in attendance from the members in component societies who are our good neighbors. I only hope that this great work will serve to underscore and strengthen the belief that you have already demonstrated on the part of the medical societies themselves in the necessity of maintaining an academic system of education free and unhampered by the necessity of federal subsidization.

Again, my deep and heart-felt thanks for your loyalty not only to this project, important as it is, but to the Medical Society behind whom you stand so strong.

Kindest regards,
*Newland E. Day, M.D.*
Chairman, Committee
to Cooperate With the A.M.E.F. of the
Medical and Chirurgical Faculty

# COMING MEETINGS

## OTOLARYNGOLOGICAL SECTION OF THE BALTIMORE CITY MEDICAL SOCIETY

C. CARLETON DOUGLASS, M.D., *Chairman* ALBERT STEINER, M.D., *Secretary*

*Tuesday, January 12, 1954*

*Johns Hopkins Club, Homewood Campus*

*Cocktails 6:00 p.m. Dinner 6:30 p.m.*

Surgical Approach to Head and Neck Cancer in Man. Robert Smith, M.D., Chief of Surgery, National Cancer Institute. (By invitation.)

Discussion by Grant E. Ward, M.D.

## BALTIMORE CITY MEDICAL SOCIETY

Osler Hall, 1211 Cathedral Street

*Friday, January 15, 1954, 8:30 p.m.*

Regional Enteritis. Burrill B. Crohn, M.D., Consultant Gastroenterologist, Mount Sinai Hospital, New York City, and Consultant Gastroenterologist, Columbia University College of Physicians and Surgeons, Postgraduate Medicine, New York City. (Illustrated.) (By invitation.)

Chronic Idiopathic Ulcerative Colitis—Problems in Etiology and Management. Thomas E. Machella, M.D., F.A.C.P., Chief, Gastrointestinal Clinic, Hospital of the University of Pennsylvania, and Associate Professor of Medicine, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania. (Illustrated.) (By invitation.)

Question Period.

## ANESTHESIA STUDY COMMITTEE

Faculty Building, 1211 Cathedral Street, Baltimore

*Wednesday, January 20, 1954, 8:30 p.m.*

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the Baltimore City Health Department

## THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Faculty Building, 1211 Cathedral Street, Baltimore

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty

RICHARD W. TELINDE, M.D., *Chairman* BEVERLEY C. COMPTON, M.D., *Secretary*

*Thursday, January 21, 1954, 5:00 to 6:00 p.m.*

## MATERNAL MORTALITY COMMITTEE

Faculty Building, 1211 Cathedral Street, Baltimore

*Thursday, January 28, 1954, 4:00 p.m.*

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and the Baltimore City Health Department

MARK THESE DATES ON YOUR

CALENDAR NOW

AND PLAN TO ATTEND

# *The Annual Meeting*

of the Medical and Chirurgical Faculty

✶

TUESDAY, APRIL 27, 1954

AND

WEDNESDAY, APRIL 28, 1954

*Business Meetings,* MONDAY, APRIL 26, 1954

*Faculty Ball,* MONDAY EVENING, APRIL 26, 1954

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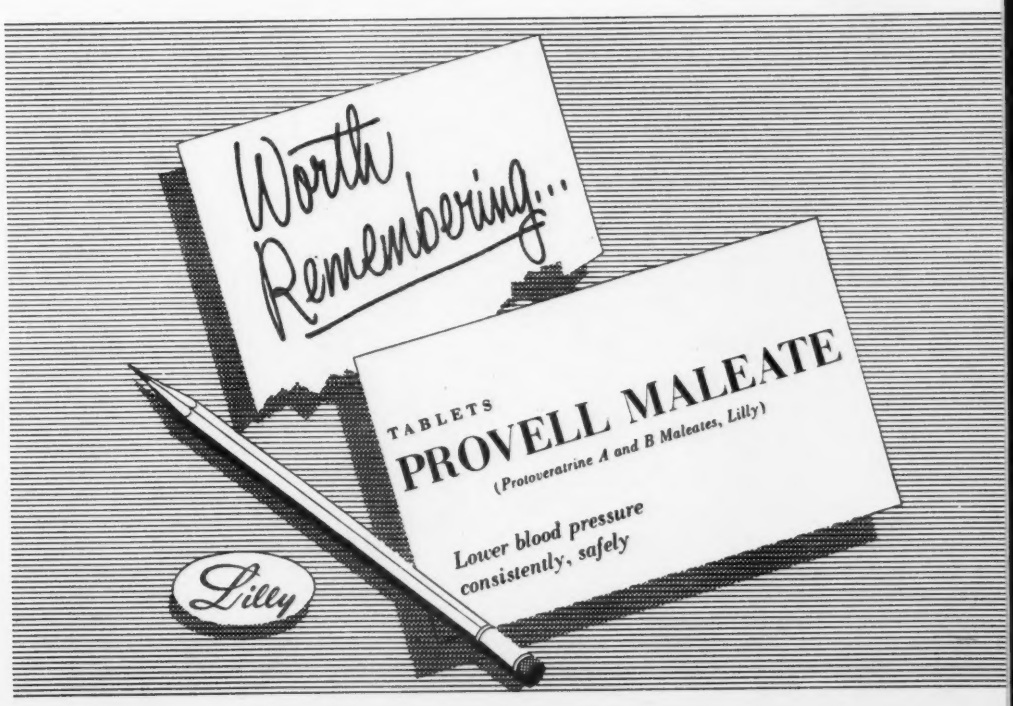
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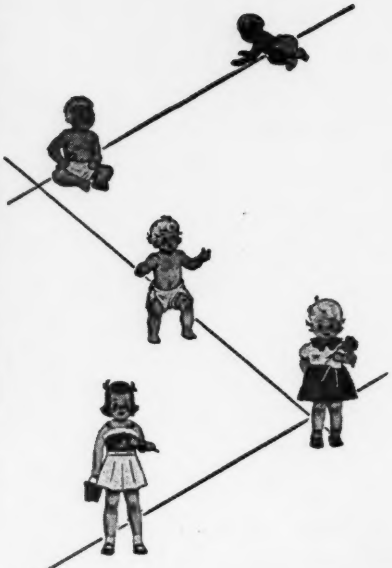
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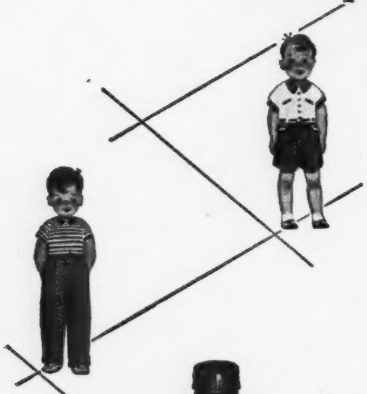
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